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The Crisis in Foster Care

New Foster Care Approaches

Foster Children as Adults

Development of Blind Children



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Father and son exploring the origins of time, and revealing in the process the quality of father-child relationship every child needs. Finding this type of relationship for children who cannot be with their own parents is one of the aims of the experiments in foster family care described in this issue.

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In this country, with its strong belief in the value of family life, the goal of the child welfare field has long been "a home of his own for every child." Yet today, in many parts of the country and especially in our large cities, "temporary shelters" are crowded with children who have lost their own homes temporarily or permanently and for whom no other homes are available. We need look no further than our Nation's Capital where, as a national magazine has recently pointed out,¹ more than 900 children were sheltered in the winter of 1964 in the largest public institution in the United States for "dependent" children. Half of them were under 6 years old, and half stayed more than 3 months. Information from the institution shows that the number in care has since decreased. This is attributed to more realistic public assistance policies and better employment opportunities in the area, the establishment by the welfare department of emergency shelter apartments for mothers and children, and an increased effort to find and obtain foster homes. However, nearly 700 children continue to live in crowded conditions in the shelter without any semblance of family life—at a cost of about \$300 a month per child.

Washington, D.C., is not an exception. Chicago has a similar problem. In New York City at the end of 1964, about 2,000 children were awaiting placement. Some were well babies who had been in hospitals for over a year. Others were older children packed into overcrowded "temporary shelter." Children have been known to stay in such shelters as long as 3 years.²

In fact, discussions with foster-care agency personnel in various parts of the country indicate that most of our great cities growing numbers of children

MEETING THE CRISIS

N FOSTER FAMILY CARE

BEATRICE L. GARRETT

to living in potentially harmful conditions awaiting placement. Others, already in temporary foster homes, are awaiting more permanent arrangements. And, while the number of children needing homes increases, foster family and adoptive homes are becoming proportionately less available. Furthermore, as the country becomes more urbanized, the problem is likely to increase throughout the Nation. A survey recently conducted by a magazine reporter indicated that efforts to provide constructive foster family care for children are already in a critical phase in at least 41 of our 50 States.²

Three major factors have helped to produce this appalling situation: rapid socioeconomic changes affecting the population from which foster parents must be recruited; changing characteristics of the children needing foster care, including more with appreciable emotional disturbance; and administrative problems, including the chronic shortage of staff in child welfare agencies, both professionally educated and agency trained.

Obstacles and impediments to resources

Among the socioeconomic changes affecting the availability of many families to provide foster care are two interrelated phenomena: (1) the increasing mobility of our population; and (2) the changing nature of our great metropolitan areas, more and more crowded at their cores with unskilled newcomers from rural areas, and ever widening at their rims into new suburbs inhabited not only by the well-to-do but also by many families of skilled and semiskilled workers who are not yet adjusted to this type of community living.

In the inner city, few families except the well-to-

do can afford housing with enough space to take in an extra child. In the suburbs, the new inhabitants are often isolated from the problems of the larger community and too unsettled to become participating members of their local community life,³ let alone to open their homes to the care of someone else's child. Moreover, in many of these families both husband and wife go out to work, thus rendering the family unable to care for a foster child.

The children

The same socioeconomic changes which tend to reduce the availability of foster families tend to increase the number of children needing care. The rapid migration to the cities of rural families unprepared for city life makes for a breakdown in family life. Because large proportions of these new city dwellers are from minority groups, a large proportion of the children crowding the cities' "temporary shelters" are children from minority groups—especially Negroes, Puerto Ricans, and other Spanish-speaking Americans—children for whom foster and adoptive family resources are least available because of the lesser affluence of these population groups in general in comparison with the population as a whole.⁴ In the Washington, D.C., shelter, 97 percent of the children are Negro.¹ About 70 percent of the children awaiting placement in New York City belong to minority ethnic groups.² In Richmond, Va., the number of Negro children in foster care increased 164 percent in the 8 years ending July 1, 1964, as compared with a 60-percent increase in white children in foster care.⁵

Agencies have repeatedly noted the greater prevalence and degree of emotional disturbance today

than in the past among children who are brought to them for foster care. This can be attributed, at least in part, to the fact that many relatively stable families which in the past might have been broken because of economic need alone are today able to remain intact because of their own participation in the country's general economic prosperity or because of Federal, State, and local income maintenance programs. Thus, the children who do need foster care today are more likely to be those whose separation from their parents is directly attributable to parental instability.

Before they have come to the community's attention, many of these children have already had damaging experiences in their own homes. Some have been severely neglected or have been abused. Therefore, they have learned to defend themselves against adults, to be suspicious, and not to trust themselves, or their affection, to others. Such a defensive pattern on the part of a child makes it difficult for a foster parent to learn to love him and to live with him 24 hours a day.

Many of these children need only temporary foster family care, or the kind of temporary group care which can provide a semblance of family life, until they can be returned home. Others can never be returned to their own families, including some who need only temporary foster care until they can be placed for adoption. But a large and increasing number, because of special circumstances—their age, a physical or mental handicap, an emotional problem, or simply their race—face the bleak reality of long-time "temporary" care unless unusual efforts are made to find them permanent homes. Tragically, this group includes children who might once have been returned home, or who might never have had to leave home, if appropriate casework help, financial assistance, and other services had been available to their parents earlier. It also includes children who might once have been placed for adoption but now are too old or too emotionally damaged for adoption to be a realistic possibility for them. Too often, staff shortages and other administrative difficulties—such as a failure to reexamine agency practices—have stood in the way of helping children to have the kind of family home they need.

Innovative approaches

Agencies throughout the country, keenly aware of this foster-care crisis, have tried a variety of approaches to break the bottlenecks which keep chil-

dren from having homes of their own. Special recruitment efforts to find foster families have become commonplace, as have special efforts to find adoptive homes for Negro children and other children for whom adoptive homes are not readily available. These efforts have helped but not solved the problem for no one approach or effort can do so.

Therefore, many agencies are seeking new approaches. Some of these are described in the short articles following this one. They are presented not as panaceas but as experiments worth watching as learning from as new efforts are made.

The foster homefinding experiment described by Mother M. Ann Michaela, for example, recognizes the often overlooked resources in the kind of neighborhood from which most of the children in shelter care come—an inner-city neighborhood. Impressed by the potentialities for foster care of the many stable families who reside in public housing projects, the agency has been fortunate in not having to face the usual obstacle to placing children into such families: the housing authority's assignment of apartments according to size of family.

This kind of focus on a neighborhood familiar to the child needing placement may be especially useful for finding temporary homes for children who may be returning to their own families in a week or even a year. Such children need to be in a home near enough to their own homes for the parent-child relationship to be maintained and strengthened by regular visits by the parents while the child is away from home. Many possibilities for the welfare of children may be found in further exploration of such a neighborhood approach. For example: Could an agreement be worked out with the housing authorities to allocate a number of apartments for foster families? Could an agency rent and maintain houses for foster families in neighborhoods having a high incidence of parent-child separation? Would training and w-

Beatrice L. Garrett, Children's Bureau specialist on foster family care, came to the Bureau in 1962 from the Child and Family Services of Knoxville, Tenn., where she was executive director. During World War II, she was with the American Red Cross in London and Paris. She has also worked for the Tennessee Department of Public Welfare, and the Family Service Society of New Orleans. She received her master's degree in social work from Tulane University.



th foster families in these neighborhoods tend to strengthen family life in the neighborhood generally?

An example of an agency's experience in renting and maintaining houses for foster families is illustrated in the article by Catherine Pratt.

Other types of neighborhoods may also provide a source for foster family homefinding. Many families living in suburban isolation might have real potential for preadoptive care, long-range foster care, or for taking an emotionally disturbed child into their homes as part of the agency's treatment plan. A study previously reported in *CHILDREN* has suggested that untapped resources may lie in the suburbs, particularly among working wives who would prefer to supplement their husband's income by suitably paid home-based service than by going out to work.⁶

Foster family recruitment efforts with specific child characteristics in mind, aimed at specific target areas, might bring more promising results than a shotgun approach to recruitment.



A caseworker observes the warm relationship which has developed between this man and his two foster children.

olicies and practices

Whatever the resource tapped for foster family homefinding, placement practices must protect the child insofar as possible from the shattering experience of removal from a successful foster home. This demands some serious consideration of the following questions: What plans are necessary and possible for continued agency supervision of the family and accountability for the child when a foster family moves across county or State lines? What payment or service, what commitment on the part of the foster family, and what kind of training of foster parents are necessary to assure that the difficult work of caring for a child who has already undergone damaging experiences will be rewarding enough to the foster family to assure continued care?

Foster parents of emotionally disturbed children need a great deal of help, support, and training from the agency to be able to understand and "take" the vagaries in the child's behavior and to understand how their parental role differs from the role of natural parents. The chances that they will be able to earn on the job and use close supervision may be greater if they are taken into the agency as full-edged members of the agency's staff. Moreover, is it not better for the child if foster parents secure their reward through employee status, just payment, and vocational satisfactions, rather than for them to expect to be rewarded by the immediate affectionate

response and "good behavior" of a frightened, distrustful child?

Perhaps the provision of special training courses, adequate payment, and the prerogatives of agency employment would also help to reduce the costly turnover in foster parents—an important factor in the foster family shortage. The experiment Miss Pratt describes is based upon this point of view. But payment for services of the foster family in addition to the child's maintenance is a rare practice in the child welfare field today, in spite of the time, energy, and skill required of the foster parents in caring for a child.

Much of the scarcity of foster parents may also be due to restrictive selection policies on the part of agencies. Many agencies exert a great deal of energy in recruitment drives and then select as foster parents only 5 to 10 percent of the families who respond. Could more of these applicants be advantageously accepted and the turnover of accepted families be reduced, if agencies would focus on increasing and supporting their strengths through intensive casework service and through orientation and training programs?

None of these possibilities can safely be built into a program of foster family care without plans to increase the quality and size of staff in child welfare services. Moreover, the critical situation in foster family care spotlights the pivotal importance of those services which can prevent parent-child separation in the first place—casework services to the

parents, homemaker services, day-care services, and a realistic public assistance program. Another major factor in the foster-care crisis is the misplacement of children in foster families who would have been better served in a different kind of foster family, or in group care. If such tragic mistakes are to be averted, the caseworker must have the time and skill to determine the kind of service the child needs and to find or develop the appropriate resource. Major blocks to achieving this are the underfinancing of child welfare services programs and lack of emphasis in staff development programs on teaching the specialized skills required.

Long-range care

Regrets over what might have been cannot be allowed to interfere with efforts to help the children who no longer have a chance for returning to their own homes and whose chances for adoption are extremely slim unless the agency establishes unusual methods of developing adoptive homes. Many child-placing agencies are testing out ways of meeting these children's needs. Experiments in placing such children in "permanent" or "quasi-adoptive" family homes where there may be a hope for future adoption are described in the articles by Vivian Hargrave, Aileen B. Ostazeski, and Elizabeth A. Lawder. In other plans, agencies are trying out "guardianship" homes; others are subsidizing adoptive parents, for a limited period of time either before or after legal

adoption, and for special purposes, such as surgery for the child or other medical treatment.

The various experiments in trying to provide "permanent" families for children are, as Vivian Hargrave points out, an attempt to plan consciously for something that has long been happening to children remaining in foster care throughout their childhood. Elsewhere in this issue, Elizabeth G. Meier reports some encouraging results of long-range foster care. The majority of young adults in her study—all of whom had been in foster family care for 5 years or more—have made strikingly better adjustments than had their natural parents.

There are, however, some differences in the placement programs under which Dr. Meier's respondents received care and the "permanent" care programs planned today. Forty-two percent of the girls and 35 percent of the boys in the Meier study had the foster care in "work" or "free" homes,⁷ but in today's plans the agencies may continue to take full financial responsibility for the child. Moreover, the placements referred to in the Meier study had taken place in a largely rural environment at a time of economic depression. Today the socioeconomic climate has changed and may well have an effect on the results of child placement. Therefore, it is necessary to question, to test out, and to adjust planning in relation to today's circumstances.

Careful scrutiny needs to be given, for example, to the foster family's conscious and unconscious reasons for wanting to take a foster child for permanent foster care rather than adoption. In our eagerness to find a family to which a child can feel he belongs, there is a real danger of rationalizing the foster parents' motivation for offering permanent foster care.

Is financial inability to adopt, or a longtime fear of financial insecurity, the real reason behind the foster parents' choice? Or is this a cover for anxiety about how the child will "turn out"—a lack of faith in the child and in themselves? Vivian Hargrave indicates that some foster parents who want a foster child to be part of their family question their own ability to be supported to meet the child's developmental needs but have strengths that can be supported and developed through casework service.

However, there may also be some prospective foster parents who cannot take a child for temporary care because of their sense of rivalry with the child's own parents and the desire not to have the parent visit the child. Therefore, as Aileen Ostazeski points out, these couples may choose to provide long-range foster care in which they do not expect to have to de-

Prospective foster parents, at a social agency, meet the child who is to be placed in their home for care.



with the parents. Is this a healthy reason for their choice? Such prospective foster parents do not realize that the natural parents, still present in the child's phantasy, cannot be avoided. Could the foster parents be helped to a better understanding of this? Could they be helped to work for the child's understanding and acceptance of his own parents?

Unanswered questions

Each of the following examples of programs for long-range foster family care has unique features. And each poses some explicitly stated questions which the sponsoring agencies hope will be answered with developing experience. In addition, there are numerous practical questions about which the agencies must make policy decisions without a body of experience to rely on.

Among these questions are:

- What should be the respective rights and responsibilities of the agency and the foster parents in permanent foster family care? What kinds of decisions must the agency continue to make as part of its accountability for the child's well-being? What kinds of decisions should be assigned to the foster parents?

- Is permanent legal termination of parental rights necessary before long-range foster family care can be considered for a child?

- Should the agency continue to reimburse the foster parents for all maintenance costs as long as the child is in foster care? Should the child use the foster family's medical facilities or those of the agency?

- In what ways, if any, should casework supervision of the foster family differ in permanent care from that in temporary care?

- Should the child take the name, legally or otherwise, of the foster parents?

- In what circumstances, if any, and for what purposes should the natural parents or other relatives of the child be allowed to visit him?

- Should there be written or verbal agreements that the foster family expects to adopt the child?

All of these questions are intimately involved in the overall question of what kind of agency planning will make permanent foster family care a constructive experience for children and for foster parents.

The times call for critical innovation and a critical appraisal of policies, procedures, and methods in foster family care. At the same time, agencies must keep clearly before them their ultimate goal, the provision of the best service possible for every child.



Separated from his own parents, this toddler turns to his new foster mother for comfort, security, and love.

In short, the first imperative in any child welfare program must be the provision of the preventive and protective services that can help keep children with their own parents or other relatives when this is best for them. When this is not best, the need is for differential planning for placement of children according to their specific needs and characteristics. Temporary foster family and group-care arrangements are needed to care for children in emergencies and on occasions when they must be separated from their parents for their own protection while work goes forward toward their early reestablishment in their own homes. Adoptive homes are needed for children of all ages, and this means special planning for children with special problems. In addition, a

purposeful, planned program of long-range foster care is needed, which for some children may prove to be an avenue to adoption. Only when such a continuum of services is available will the foster-care crisis be overcome.

¹ Anderson, J. W.: A special hell for children in Washington. *Harper's Magazine*, November 1965.

² Haitch, Richard: Children in limbo. *The Nation*, April 1963.

³ Wyden, Peter: Suburbia's coddled kids. Doubleday & Co., Garden City, N.Y. 1962.

⁴ Herzog, Elizabeth; Bernstein, Rose: Why so few Negro adoptions? *Children*, January-February 1965.

⁵ Richmond Area Community Council: A study of substitute care of children. Richmond, Va. 1965. (Mimeographed.)

⁶ Simsarian, Frances P.: Foster care possibilities in a suburban community. *Children*, May-June 1964.

⁷ Meier, Elizabeth G.: Current circumstances of former foster children. *Child Welfare*, April 1965.

Community-Centered Foster Family Care

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Enthusiasm is a potent factor in any community. Because of it, 110 children who might have remained in institutional care were placed in foster family homes. The most remarkable part of the story is that the community is in one of the crowded, low-income areas of New York City—East Harlem. We believe that what has happened here is proof that there are resources for the care of children without homes even in an economically poor community.

Our agency, the McMahon Memorial Shelter, is a voluntary agency, operated by the Franciscan Missionaries of Mary, which accepts children from the courts and from the Bureau of Child Welfare, New York City Department of Welfare. Traditionally,

it has provided "temporary" group care for children who require emergency placement because of a sudden crisis in the family, neglect, or the need for protection.

Temporary care, by definition, should last no longer than 3 months. But in recent years some children have stayed at the shelter for a year or more because severe pathology in their own families precluded their return home and foster homes could not be found for them through the usual child-placing channels. This was particularly true of our Negro and Puerto Rican children. Last year, we decided we had to find a new resource. Therefore, we determined to do our own homefinding so that children badly in need of individual love and attention could remain in a warm family atmosphere until a more permanent plan could be made for them.

We began by appealing to our own employees, most of whom live near the shelter. We explained the plan to them and asked them to tell their friends about it.

The idea worked better than we had dared to hope. An employee told a friend, the friend told another. Soon the news had spread all over the neighborhood, and prospective applicants began ringing our doorbell to inquire about the program. Much of our routine preparatory work was done for us as applicants helped others to fill out forms and alerted them to the need for medical data and letters of reference.

The greatest source of homes turned out to be families living in the large public housing projects in our neighborhood. This source had been opened up by agreements worked out by the city welfare department and the city housing authority as a basis for foster family recruitment program in 41 housing projects.

We held our first group meeting for applicants in November 1964. Twenty-three couples came. We explained the plan and the function of the shelter, the contribution foster parents could make to the welfare of a child, and the relationship that would exist between the foster boarding home and the shelter.

When we said that we wanted to keep the children of a family together if possible, the reaction was spontaneously favorable. One man suggested that as he and his wife and Mr. and Mrs. X, another couple at the meeting, lived across the hall from each other, one family could take one child and the other his sister. Others at the meeting also expressed interest in such an arrangement.

A social worker and a nurse from the shelter's staff, working as a team, evaluated each home carefully, concentrating particularly on family relationships. The standards of the New York State Department of Social Welfare were the criteria for certification.

The 110 children we have accepted since November 1964 were placed in 46 foster families. All but eight of these families live in public housing projects, and 41 are either Negro or Puerto Rican. They are of various religious faiths. About 80 other families are on our waiting list to receive children. While the program was devised chiefly to provide temporary and interim care for children, four of the foster families have taken children for long-range care.

Because the foster families and the shelter are in the same community, we can keep in close touch with our children. They return to the shelter for visits with relatives and for psychological tests and medical attention. We believe it is important for the shelter to remain familiar to them to avoid shock should they have to return to its care for any reason.

Our goal is to create a center to which foster parents can turn with confidence. Many come with their foster children to the shelter on visits. The nurse and the social worker conduct group discussions with the foster mothers, the topics being suggested by the foster mothers themselves. Through their discussions as well as through individual interviews in the homes, the social worker and the nurse attempt to increase the strengths in the family, not only for the sake of the foster children but for the foster parents and their own children as well.

We also do all we can to give the foster parents' own children a good impression of the shelter, for many of them are encountering a social agency for the first time and at a formative stage in their lives. To encourage them to come to the agency, we have a lot recreation project in which they are invited to participate. We hope that as these children become aware of our interest in them, any sense of rivalry between them and their foster brothers and sisters will diminish.

Foster parents have told us that they feel close to the shelter because we are living with them in their own community. We, in turn, have observed the happiness and well-being of the children placed in their homes. The progress of these children is a greater tribute to the foster families than any tribute the shelter could express.

The growth of our community-centered foster home plan demonstrates that in sections of New York City, such as ours, where there are many complex

problems, strong family units do exist, units that through interpersonal relationships engender and foster the values on which family life is built.

Preparation for Permanent Foster Care

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Early in 1960, the Westchester County Department of Public Welfare realized that it was facing a serious problem in supply and demand: There were not enough foster or adoptive homes for the large and increasing number of children legally free for adoption for whose future well-being the department was responsible; and the number of applications from prospective adoptive parents was decreasing. In the division of family and child welfare, we planned to continue our extensive efforts to interest families in the community in adopting, but we became convinced that an additional program would have to be developed if each child was to be reared in a family as nearly like one of "his own" as possible.

We were determined that the needs of the child would be paramount in our plan. Since many of the children for whom we were planning would come into our care as infants, we knew we must avoid making a plan that would only lead to frequent changes in foster homes—a circumstance so many children without families of their own have had to tolerate, and which too often impairs emotional development.

Therefore, we planned for a new kind of long-range foster care, one which would provide the child with a permanent home in which the foster parents would have a greater degree of independent authority than foster parents are usually accorded. The agency, of course, would continue to be responsible and accountable for the child. But it would try to provide an environment that would permit the child to put down roots and to develop a normal child-parent relationship with his foster parents.

When we believed we had developed a sound plan, we began at group meetings for prospective foster parents to introduce the idea of taking in a child for permanent foster care. Our next move was to examine the information we had gathered about these prospective foster families. We found—and continue to find with new applicants for foster care—that they were of different ages, their incomes varied, and the majority, having children of their own, were experienced in child care. They had one characteristic in common—the desire to bring up a foster child as though he were their own child. They expressed this desire in many ways.

We began then and have continued to talk about permanent foster care with those prospective foster parents who indicate they are not ready to meet the demands of traditional foster care—with its constant threat of having to give up the child and often the necessity of sharing him with his own parents—not ready to accept full responsibility for a child through adoption. Some of these couples feel that for financial reasons they cannot adopt a child. Some have immediate financial problems and others, having struggled for years to secure their present homes, do not wish to make the financial sacrifice involved in adoption, at least as yet.

In such situations, we try to learn as surely as we can whether the child is wanted for himself. When we are reasonably certain that he is, that the foster family's motivation in applying for a permanent foster child is healthy, we proceed with the home study. This includes careful examination of the foster family's understanding of and attitude toward parents who give up their children because they cannot provide a suitable home for them. At some point in the future, the foster child will certainly ask questions about his own parents and his status as a foster child. Preparing the family to face this vitally important issue in a way that is to the child's best interest must begin in the home study itself. Since the natural parents of each one of these children have legally relinquished custody to the agency,

there will be no contact between natural parents and the child.

Permanent foster care involves many of the same elements as adoption. We select foster parents for specific children as we do adoptive parents. We ask the foster parents to act as nearly as they can as though they were the child's own parents. Therefore, since we expect this degree of acceptance, we believe we must give the parents the right to handle the day-by-day experiences of living with the foster child as they would with their own children.

Our continuing supervision has a clearly defined objective: to be of service to each person in the foster family and to encourage the family to treat the foster child as one of its own, allowing him to have real place in the family. This means that the child will grow to feel closer to the family than to the agency.

The agency serves as counselor to all members of the family as they establish relationships with the foster child. Because it permits the foster parent to act as parents to the child in every sense possible it does not attempt to control the family's child-rearing practices. Rather, it allows the control to come from the good feeling which develops naturally between the foster child and his foster parents.

With each such placement, the agency gives verbal commitment to the foster parents that the child will remain permanently in their home unless a situation develops in the home which may harm the child or which makes it necessary for the family to terminate the care. This commitment gives the foster parents a sense of a lasting arrangement and dissipates the anxiety foster parents and foster children are apt to feel when uncertainty prevails. The child is allowed to become a part of the family; and his foster parents can relax in the knowledge and security of the agency's commitment.

Thus far, 105 children have been placed in this type of care. All but three are still with the foster families with whom they were originally placed. Two placements were terminated by the agency when it was found that the foster home was not meeting the needs of the particular child. Another child had to be replaced because of the foster mother's serious illness.

All the children in permanent foster families are Negro children, attractive, healthy, average or above average in intelligence, appealing, and adoptable every way. Two showed scars of emotional deprivation at the time of placement and one had a slight physical handicap (club foot).

We are pleased with the results so far. We expect that some children will eventually be adopted by their foster parents; that others will grow up in foster care. It is a young program, but it is old enough to be reevaluated—something we are doing continually. We believe the program is most certainly providing the child and foster parents with the opportunity to enjoy the satisfaction of an arrangement that allows a healthy parent-child relationship to develop normally.

Quasi-Adoption

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In the spring of 1964, the Children's Aid Society of Pennsylvania, a voluntary child-caring agency, initiated a quasi-adoption service. After a startup period of 4 months, the first child was placed with a "quasi-adoptive family" in September 1964. By the end of August 1965, 32 Negro children were placed in 31 families. The number of placements exceeded by 7 the goal of 25 such placements within the first year.

The aim of this new service is to provide permanent and uninterrupted family living for young Negro children for whom there are no prospects of being reunited with their families. Because of the shortage of adoption homes for Negro children, modifications of practice are necessary to expand the possibility of adoption for this group of children. Quasi-adoption, then, while based upon what is known about sound adoption practice, has distinct differences.

One of the major differences is that quasi-adoptive families need not commit themselves to the outset to legal adoption, although the agency from the beginning lays the groundwork for making this outcome a distinct possibility. Families who are accepted by the agency for the service are emotionally

committed to care for a child permanently. Discussions with prospective quasi-adoptive parents include their motivation for parenthood, their emotional commitment to taking a child into their home, and their anticipated ability to provide for the child throughout his childhood. All quasi-adoptive parents are informed during the home study that the child is potentially free for legal adoption and that the agency hopes that this final step will be taken by the family at some point.

Discussion during the home study of how much assistance the family needs and wants with the cost of the child's care leads to the decision of how much financial responsibility the agency agrees to bear. In some instances, the Children's Aid Society agrees to pay for board, clothing, and medical care for the child, and in others the agency pays only part of these expenses. Before the petition for adoption is entered, however, the family takes on full financial responsibility for the child. Discussions of financial responsibility are, of course, related to the whole of the family's functioning and are considered an important ingredient of the casework service the agency provides.

The characteristics and needs of the quasi-adoptive families appear to differ from those of the more conventional adoptive parents in that many of the quasi-adoptive families seem to need basic family casework in solving some of the economic and social problems which may stand in the way of a richer family life. Any family accepted must have emotional stability and sufficient financial security to undertake the care of a child. However, casework service is offered to help raise the general level of family functioning so that the family as a whole benefits. Budgeting, household management, financial planning, and housing are concrete areas in which the families may need help.

All children selected for placement in quasi-adoption are legally available for eventual adoption, are healthy, are developing normally, and are under school age. The selection of families for children and vice versa is strongly influenced by the image the quasi-adoptive parents present of the kind of child they wish to have. Most of the couples applying for children through this service have definite ideas about the kind of child best suited to them. It has become clear during this first year of this service that careful selection is the cornerstone of successful placement.

The 32 children placed within the first year of the new service ranged in age from 1 week to 5 years, 3

months, the range being determined by the requirement that all children be below school age. The characteristics of the quasi-adoptive parents, however, are only loosely governed by objective eligibility requirements; such requirements are flexible. The median age of fathers was 40 years; the range was from 22 to 55 years. The median age for mothers was 38 years; the range was from 21 to 50 years. The median income was \$5,200; the range was from \$3,600 to \$10,000. The median education for fathers was 11 years; the range was from 5 to 16 years. The median education for mothers was 11½ years; the range was from 6 to 14 years. The majority of families were buying a home. All families were Negro.

This new service grew out of a growing community concern over the emotional damage mounting in the many Negro infants and young children who, because there were no homes for them, remained for excessive lengths of time in the Philadelphia General Hospital and the temporary shelters of the Philadelphia Department of Public Welfare. At the same time, the Children's Aid Society was receiving applications for children from families who were neither prospective adoption applicants nor prospective foster parents in the conventional sense.

In the winter of 1964, the Children's Aid Society presented its plan for a quasi-adoption service to both the Philadelphia Department of Public Welfare and to the United Fund, the local fund-raising organization for voluntary social services. The plan was accepted enthusiastically by them and also received the blessing of the Health and Welfare Council. Close collaboration between the staffs of the Children's Aid Society of Pennsylvania and the Philadelphia Department of Public Welfare for purposes of casefinding has been developed. All children accepted for the service are referred to it by the public welfare agency.

Quasi-adoption is new, and many questions about it must remain unanswered until there has been more experience. The following are but a few of the questions we hope to answer in time: Will the supply of families continue? Will this method of adoption reduce the number of outright adoptions of Negro children? How many families who take children through this service will legally adopt them? What kinds of psychological problems arise in this type of arrangement? What kinds of practical problems develop? Can quasi-adoption be used for other types of hard-to-place children?

One year is only a beginning. So far the results are promising. Quasi-adoption placements have ex-

ceeded our expectations, and in the same year the number of Negro children placed for adoption through our conventional adoption service increased

A Statewide Policy for Permanent Foster Care

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In 1963, the Lutheran Social Service of Minnesota received a request for a Negro foster child from a white couple who had been impressed by recent publicity about the shortage of adoptive or foster homes for Negro children. The prospective foster parents expressed their intention of giving permanent care to the child, but had some hesitancy about adoption. Uncertain about the ability to handle all the problems which might arise, they wished to have the continuing help and supervision of the placement agency.

Since there was a prevailing tendency to regard foster home placements as temporary, the Lutheran Social Service turned to the Hennepin County Welfare Department and the Minnesota State Department of Public Welfare to determine if permanent home placements could be made. The experience of these departments strongly pointed up the need for permanent homes for children for whom adoption was either not feasible or not available. There resulted the development of a cooperative program between the Lutheran Social Service and county welfare departments for the planned placement of children into foster families for care throughout the childhood, and, eventually, in the establishment of the Minnesota State Department of Public Welfare of statewide standards for permanent foster care.

The resulting interest in permanent foster family care, along with the findings of Elizabeth Meier's study of adults who were foster children through most of their childhood (see p. 16), stimulated social workers in the State to reexamine their foster-care standards, policies, and practices.

We found we had no guidelines or policies for the planned use of long-range care. The State's standards for foster boarding homes, agreements with foster parents, and public welfare manuals all reflected the concept of foster care as a temporary service, and gave little status to its use as a long-range plan. Although voluntary agencies and county welfare departments were placing children for long-range care, they assumed they did not have approval of the State agency for this type of placement.

In 1964, the Minnesota State Department of Public Welfare responded to pressure to develop State guidelines and policies for long-range care. It was becoming evident that a distinction in programming short-range and long-range foster care was necessary.

The department began with a survey of 95 children under State guardianship in three counties in order to identify those children for whom permanent foster family care is an appropriate and realistic plan and those who are actually in placement in permanent homes, whether or not by original intent. The findings indicated that a large proportion of the children who had been in foster care for a long time were well established as members of their foster families. Nevertheless, a review of their records indicated that agencies responsible for their care still had plans to place them "eventually" in adoptive homes. Although the "temporary" placements had turned into extended placements, the status of children in their foster families was in limbo.

As a result of this study, a committee was formed of representatives from the State agency, four county welfare departments, and two voluntary child-placing agencies to examine the issues which must be considered in planning permanent foster family care for children. The committee set out to clarify the respective responsibilities of permanent foster parents and the placement agency, to examine legal and policy problems which deter the assimilation of the foster child into a foster family, and to determine the kind of social casework and financial services permanent foster parents need.

After a year of study, the committee identified the following principles:

- A program to provide permanent foster families

for children cannot be effective unless the agency's staff accepts the idea that this type of care is a necessary and constructive service for some children. Delay in making a decision for long-range foster care because of an unrealistic goal of adoption denies the child an opportunity for full family life. Agencies should regularly evaluate the status of their children in foster care and make more permanent plans for those threatened with extended "temporary" care.

- After the child has been placed in a foster family where the agency and the foster parents believe he can remain permanently, both must work together to sustain the placement.

- A formal agreement between the agency and the foster family—with the "intent" of permanency clearly stated—helps to cement the relationship between the foster family and the foster child.

- The agency should provide permanent foster parents with casework service and financial aid in a manner which will help them feel like parents to the child. Permanent foster parents should be given more freedom to make decisions affecting the foster child than can be allowed families providing temporary foster care.

The promulgation of these guidelines spurred increased activity in providing this type of service. Thus far, in Hennepin County, the county welfare department has placed 48 children in permanent foster families, and in Betrami County, the local welfare department has placed 25 children in such care.

The majority of permanent placements have been interracial, a development arising from the large number of children of minority groups needing such placement. However, families from both Caucasian and Negro groups have opened their homes to children. Of a total of 38 Negro children placed in permanent care, 24 are with Caucasian families and 14 are with Negro families. The remaining 35 children, all of whom have been placed with Caucasian families, include 23 Indian children, 11 Caucasian children, and 1 Puerto Rican child.

Finding the families who wish to give permanent care to a child has never been a problem. The Lutheran Social Service especially has discovered that many families who would not take a child for temporary care are eager to give permanent care.

Many problems must be resolved in the statewide program for placing children in permanent foster homes:

- Child welfare workers still vacillate in deciding whether to refer a child for adoption or for permanent foster family care. Often a child is re-

ferred for *both* types of placement. This interferes with sound planning for the child.

- The mobility of families today raises a problem. Placement agencies have no real assurance that a family will keep its foster child if it moves out of the State. The usual procedure is to reevaluate the placement at the time the family plans to move and to make every effort to work with agencies in other States in providing continuity of care.


- The State's policy of requiring reevaluation and relicensing of foster family homes, which applies to permanent as well as temporary foster homes, may need to be relaxed in relation to permanent homes, because of the threat to permanency implied in an annual review.

Our experience in studying these problems has made us keenly aware of our responsibility to provide consistent care to all children under the State's guardianship. The goal is to develop long-range foster care of high quality so that it will be an effective, beneficial service for the children for whom adoption or return to their own homes is not possible. Thus, it will be one facet of a continuum of services for dependent children.

Foster Parents as Agency Employees

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 In a demonstration project aimed at developing a new resource for providing a stable family life for children likely to be long-term public charges, the Family and Child Services, a voluntary agency in Washington, D.C., has employed six foster mothers as full-time agency employees, each to give longtime care for small groups

of children. Three of the foster mothers and their husbands live in their own homes; three in homes rented, furnished, and maintained by the agency. In addition to their salaries and other regular employee benefits, including vacations, sick leave, coverage in workmen's compensation, and opportunities to join retirement and hospitalization plans, the foster mothers receive full reimbursement for the cost of child care. To help them in their child-care functions, they are provided with concentrated casework services and auxiliary services related to child care.

In all the homes, the foster mother's husband assumes most of the usual attributes of a father's role except for providing for the children's maintenance. Four of these foster fathers have full-time employment outside the home; the other two, who are semi-retired, have part-time employment.

The demonstration project is financed by a grant from the Children's Bureau, U.S. Department of Health, Education, and Welfare, and by reimbursement for child-care costs from the District of Columbia Department of Public Welfare. It grew out of a recognition of the need in many large cities for additional resources for the care of children for whom neither adoption nor return to their own home is likely.

The 6 participating foster couples are caring for 29 foster children, all selected from referrals made by the welfare department. Each of five couples care for five foster children; the sixth, for four. One family also includes two of the foster parents' own children.

Except in one home, in which all the foster children are adolescent girls, the foster children in each home include both boys and girls in age ranges approximating the spread in normal families. Several homes include more than one child from the same family but in no home are all the children from one family. The overall age spread is from 3 to 16, with about half (15) the children being between 6 and 12. Of the remainder, six are under 6 years of age and eight are over 12.

All are children from families of longstanding parental inadequacy, with little chance for eventual return to their own homes. While all are believed to have capacities for development in a foster home none is regarded as having an opportunity for adoption, the obstacles being lack of adoptive applicants, legal involvements, or the inability of the child to meet the emotional expectations of adoptive parents. All have previously been in institutional or foster family care for from 1 to 9 years, the median length

of stay being 5 years. Twenty-two children had been in both types of care. The number of previous placements per child ranged from one to nine; the average was three.

The agency took 23 months to recruit and select the foster parents for the project, obtain three houses, and select and place the children. The selection of foster parents took longer than is usual in traditional foster care. Studies of applicants were lengthy and detailed. The agency had to learn how well the prospective foster parents had functioned and were functioning as members of a family and of society. It spent much time in orienting applicants to the nature of the plan—the expectation of long-time care and the respective responsibilities of foster parents and agency. Preliminary work included an evaluation of the willingness of the applicants to make long-range commitments, to share their responsibilities freely with the agency, to accept the children selected for them, and to seek and use the help of the agency in developing their own child-rearing skills and building on the strengths in the children. Only one of the couples selected had had experience as foster parents under social agency auspices, although all had had experience in child care.

The program has been in operation for too short time for conclusive findings. Only three of the families in the demonstration have had their full group of five children for a year or more. However, the experience thus far is promising. These three "artificial families" are beginning to resemble natural families in many ways. The foster parents show in many ways their acceptance of the arrangements as permanent. For example, a social worker heard a foster father preface a remark to his teenage foster daughter with "When I walk down the aisle with you on your wedding day . . ."; and a foster mother say of her younger foster children, "When they are ready for high school, we'll have a new school nearby." The sense of permanency seems to have freed these foster parents to invest their love in the children to a degree not possible when an arrangement is regarded as temporary.

The agency believes that the sense of permanency is equally strong in both types of homes. The three couples in their own homes have voluntarily purchased larger homes to make more room for the foster children. The three couples in homes supplied by the agency show no insecurity in their greater dependence on the agency. In the agency-supported homes, the agency intrudes in the household operation as little as possible. In the two in which the

children have been in the families for more than a year, the children think of themselves more as members of a family than as wards of the agency.

Recently, 14 of the children who have been in the project longest were asked, for research purposes: "If you had some trouble or were worried, whom would you like to talk to about it?" Of the six children in agency-supported homes, five indicated the mother, and one the foster father. Of the eight in the foster families' own homes, five chose the foster mother; one, a foster brother (also a foster child); one, the caseworker; and one, the project director.

The foster mothers seem well satisfied as agency employees. They speak of "my agency" and "my job." They introduce the caseworker as "my supervisor" and refer to her, the project director, and the executive secretary of the agency as "my bosses." They see themselves as accountable to the agency and responsible for accepting supervision and direction. Some are beginning to develop professional skills in understanding and dealing with the behavior and interaction of the children.

All of the foster fathers take an active interest in the children. While they see their wives as having the major child-rearing task, they provide the children with much emotional support and help out in their care and discipline.

The research the agency is conducting as the project moves along will try to determine whether a natural family group can be maintained and the roles of the agency and the parents remain compatible under a plan such as this. It will also evaluate the extent of the children's developmental progress and of change in their sense of identification and belonging; and will try to determine what factors in a child's personality and past experience may favorably influence adjustment in foster homes such as these.

Last spring, the local antipoverty planning organization contracted with the agency for the establishment and maintenance of five additional foster homes, utilizing the salient features of the demonstration. However, these homes are being used primarily for groups of brothers and sisters who have been separated from their own parents for shorter periods of time than the children in the demonstration and who may still have a chance to return to their own families. Because of the absence of a sense of permanency and the closer relatedness of the children to each other and to their own parents, these homes are expected to present the agency with different problems and results.

ADULTS WHO WERE FOSTER CHILDREN

ELIZABETH G. MEIER

What effect do the age a child is placed in foster care, the number of replacements he undergoes, and the nature of his experiences before placement have upon him in his adult life? Some light has been shed on these questions, with some unexpected results, through a recent followup study of former foster children sponsored by the Minnesota Department of Public Welfare.

The subjects included 66 men and women between the ages of 28 and 32, who in their childhood had experienced 5 years or more of foster family care, and who had not been returned to their own families while they were children. As foster children they had been in the guardianship of the State of Minnesota and under the direct care and supervision of social agencies. Many of them, before placement, had been sorely neglected by parents who manifested gross social and personal pathology.

Since the study was begun in 1959, the lists of children discharged from guardianship between July 1, 1948, and December 31, 1949, were used for selecting subjects. Ninety-eight fulfilled the three criteria of age range, length of foster family care, and not having been returned to their families' care when they were children.¹

The sample of 82 persons from among those 98 consisted of all the 34 men who were eligible on the bases of the criteria and a random sample of 48 women from among the 64 eligible. From among the 75 persons in this sample who could be located, 61 were interviewed (21 men and 40 women) and 5 others (3 men and 2 women) provided information by mail on a self-administered questionnaire. Nine persons refused to participate.

The current circumstances of the 66 participants—

their present locations, living arrangements, economic circumstances, marital status, parenthood, and social relationships—have been described elsewhere.

The research plan also required determining, if possible, whether the adjustment of these former foster children bore a relationship to (1) age of entry into foster care; (2) number of foster home placements; and (3) experiences of hunger and violence prior to placement.

To test the significance of these factors, each person was rated for "social effectiveness" and "sense of well-being." These attributes were selected as important aspects of "outcome," since the intent of foster care is both utilitarian and humanitarian—to help the child to become a socially productive adult and to derive satisfactions from his experiences.

"Sense of well-being" is a difficult concept to define for purposes of research. In the study, the criteria by which it was assessed were: *a feeling of adequacy in performing the functions for which the individual is responsible and the experiencing of pleasure in carrying out the activities in the various areas of adaptation.* Of course such feelings do not encompass all facets of this complex concept.

Social effectiveness is a less complex concept, involving more factual and even observable data.

The areas of functioning rated for social effectiveness and sense of well-being were: (1) home surroundings and housekeeping standards; (2) employment and economic circumstances; (3) health; (4) support and care of children; and (5) social behavior outside the family group. Marriage, *per se*, was not rated for social effectiveness, but the sense of well-being in marriage was rated.

Some of the information given by persons in self-

administered questionnaires could be used to evaluate aspects of social effectiveness. However, only interview information could be used to assess the sense of well-being; for this and other reasons, all subjects could not be rated on all aspects of the inquiry.

Areas of adaptation

Home and Housekeeping. Interviewers observed the housekeeping standards and condition of the home and evaluated these as excellent, good, fair, or poor. A "poor" rating was the only one judged as lack of *social effectiveness*. Both men and women were rated. The homemaking skills of women are clearly indicative of their social effectiveness. In a man's home, of course, the quality of housekeeping depends on his wife. Yet living in a well-kept home is also an aspect of the man's functioning and of the community's evaluation of him.

The vast majority of these former foster children were found to be living in neat, attractive, well-cared-for homes. Of the 20 men rated in this area, all received positive ratings, as did 33 of the 38 women rated. In one of the four homes given a negative rating, the housekeeping standards were so low as to imperil the health and well-being of children. However, there were more instances in which the housekeeping standards might have been criticized as too tidy than there were of poor housekeeping. Yet, when these adults were children, many of them had lived in appalling physical surroundings prior to their placement in foster care.

For men, assessment of the *sense of well-being* in this area was determined by their expressions of pride or pleasure in the home, negative ratings being based on expressions of apology or shame. The assessment criteria for women included, in addition, the subject's ability to accomplish household tasks without strain, her idea of what her husband thought of her housekeeping, her own appraisal of it, and her pleasure in homemaking.

Of the 17 men rated for the sense of well-being, 15 received positive ratings, and 2 received negative ratings. Practically all of the men expressed a sense of pleasure about their homes. Many had used a great deal of their spare time in making structural improvements, building cupboards and shelves, painting, and decorating. The two men who were given negative ratings expressed dissatisfaction with present living quarters, but both had plans to move.

Of the 39 women rated for their *sense of well-being* in the home, 14 received negative ratings, including

4 of the 5 women rated negatively for social effectiveness. Unfavorable comparison of self with foster mother was frequently a factor in the impairment of the sense of well-being in this area. Other factors were feelings of being overburdened by household duties, resentment of the husband's failure to help, or uncertainty about his opinion of one's housekeeping. Among the 25 women who did possess a sense of well-being in this area, many credited their foster mothers with having taught them to do housework.

Work and Economic Circumstances. For men, a positive rating for *social effectiveness* in the economic area required the presence of all four of the following indicators: (1) he is employed; (2) he is able to claim a particular line of work as his own; (3) he is the primary wage earner in the family group; (4) he has been steadily employed in no more than three jobs in the last 5 years. Eighteen of the 24 men received positive ratings. Of the six who received negative ratings, only one, a man in prison, was being supported by public funds. Another was partly dependent upon friends. Most of the men who received negative ratings had, as children, been known to have physical and intellectual limitations, or had had academic difficulties in school and no vocational training.

Designation of a *sense of economic well-being* for men depended on their having feelings of accomplishment, of having improved their skills on the job, of comparing favorably with fellow workers, of deriving a comfortable living from their earnings, and of having improved their economic circumstances over the past 5 years. Only 11 of the 19 men rated for this had positive ratings. Of the eight men who had negative ratings, four also had negative ratings for social effectiveness in this area. They obviously suffered from a sense of inadequacy and derived little or no pleasure from their work. The other four actually functioned effectively in the economic area. They were rated negatively for sense of well-being because they manifested a lack of pleasure in work, a lack of pride in accomplishment, or a pervasive dissatisfaction. Mr. B, who thought of himself as a "doorstep baby," is an example.

By objective measurement, Mr. B is highly successful in his work. He is a district sales manager for a farm implement company, supervising a large number of stores in an area covering several counties. The sales in his district have consistently climbed at a rate higher than other district managers have achieved. He has, in fact, received a special company award. But Mr. B worries about his ability to keep on bettering his

own record and whether his bosses will think he is slipping.

The need for visible accomplishment and for constant activity pervades all areas of Mr. B's life. When friends come to visit, he is uneasy just sitting and talking, and usually immediately invites them to play cards. He is uncomfortable driving unless the radio is turned on.

For a long time Mr. B nursed the unhappy thought that his former foster parents, simple farmers, did not understand that his work required knowledge, skill, and hard work. He felt that they did not really know that he had become successful. He was pleased and amazed when informed that the director of the social agency that had placed him in foster care, in securing his address from his foster parents, had been told how proud they were of him.

Women received a positive rating for *social effectiveness* if the household were self-supporting. Of the 42 women, only the 3 recipients of public assistance were given negative ratings.

However, 15 of the 40 women who could be rated for sense of economic well-being were given negative ratings in this regard. A number of factors were involved: concern about temporary economic problems; a husband out on strike; excessive family medical expenses; a drinking husband; a gambling husband; an uneasy sense of living from day to day; and in a few instances probably poor management on the part of the woman. In most cases, however, the sense of economic pinch could be regarded as a rather normal aspect of this phase of the life cycle of young couples who were getting ahead in the world, buying houses, or improving their homes.

Many of the women rated as enjoying a sense of economic well-being expressed pleasure in the contrasts between their current standard of living and the deprivations of their childhood.

Mrs. D, for example, said that she made up her mind when a girl that she was going to marry someone who could support her well. "I wasn't going to have a house full of second-hand furniture like my foster home."

She recalled vividly the shame and humiliation she had felt

before she went into her foster home, when a schoolmate teased her about wearing the same pair of socks every day. She had only one pair, but she told the other girl that she had seven pairs, all exactly alike, one for each day of the week.

Fortunately, Mrs. D married a man with a good income from his own business. The D's own a home in a well-to-do neighborhood. Their sleek new car was parked in the driveway. In discussing social activities, Mrs. D said her husband took her regularly to the best restaurant in town.

Others also expressed pleasure in having the necessities as well as some of the luxuries of life, but without Mrs. D's overemphasis.

Health. In the area of health, the indicator for rating *social effectiveness* was simple, based solely on the extent to which illness interfered with responsibilities. Persons who had lost more than 10 days of functioning in the past year were rated negatively. Among the 24 men, 19 were given positive ratings; 3, negative ratings; and 2 were not rated. Among the 42 women, 34 were given positive ratings and 8, negative.

By contrast, many different indicators were used to determine impairment of the *sense of well-being*—worry, strain, diminished enjoyment, dependence upon nostrums, and other criteria. Among the 18 men rated for sense of well-being in health, 12 received positive ratings. The seven who received negative ratings included the three rated negatively also for social effectiveness, and four who were worriers three of whom had somatic complaints.

Among the 40 women rated for sense of well-being in health, only 25 received positive ratings. Among the 15 with negative ratings were 8 women who either (1) described current circumstances in terms curiously reminiscent of the past, such as illness and deaths of their mothers, or (2) directly or indirectly connected their present feeling of having poor health with childhood events.

While some of these women had diagnosed physical illnesses, the negative ratings regarding their sense of well-being were not actually connected with the ailments *per se*. In a few, there were suggestion of an "anniversary reaction," which has been described as "a tendency for reliving the childhood trauma [loss of a parent] at a specific time—for example, when a woman reaches the age of her mother's death, or when her daughter reaches the age the woman was when her mother died."³

Attention should be called to some findings not necessarily related to the ratings. Of the 40 women interviewed, all but one had had one child or more

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Among them, they had borne 129 children who had lived beyond early infancy. In addition, 15 of the women had experienced a total of 32 perinatal losses—25 miscarriages, 1 stillbirth, 5 deaths of newborn babies, and one undescribed loss. While comparisons with the general population are not possible, it seems probable that these perinatal deaths were far in excess of what would normally be expected.⁴

Marriage. While subjects were not rated for social effectiveness in marriage, they were rated for *sense of well-being*. Information about some of the persons not interviewed, in addition to that supplied by those interviewed, makes it possible to present data regarding the current marital status of 71 of the 75 persons located. Concerning the other four for whom current data are unavailable or indefinite, the two men had married at least once, and other known circumstances suggest that the two women are living within first marriages.

All 45 of the women had been married at least once and 38 were currently living with a spouse; but 5 of the 30 men had never married, and only 9 were currently living with a spouse. Among the men, 16 were living with a first wife and 3 with a second wife. Nine were known not to be living with a wife, the five who had never married and four who were divorced or separated.

Among the women, 34 were living with a first husband, 3 with a second husband, and 1 with a third husband. Of the five women not living with a spouse, two had been married once and three had been married more than once.

Ratings of the sense of well-being in marriage were based on the subjects' own ratings of their marriages, their estimates of sexual compatibility and other areas of marital functioning, and expressed attitudes toward their spouses and toward themselves as marriage partners. Of the 16 men interviewed who were living with a spouse, 12 were given positive ratings and 4, negative. Of the 35 women interviewed who were living with a spouse, 25 were given positive ratings and 10, negative.

Errors in judgment may have placed some men and women incorrectly in the positive or negative columns. Nevertheless, the two groups present a meaningful contrast. Those rated as having a sense of well-being took pride and pleasure in their spouses. They regarded their marriages as highly important. They compared their present status with their status as foster children and spoke appreciatively of now having someone really their own.

Their positive feelings usually embraced the spouse's family. Some mentioned that they had had to "learn" that their spouses were really interested and concerned about them. Some had never before had anyone with whom they could share troubles.

The 10 women rated negatively were generally unable to express emotion constructively, to respond to the needs and emotions of the spouse, or to find in him a response to their own needs. Some seemed to have a diffuse feeling that more was being expected from them than they could give—to their marriage, their children, or life in general.

The four men rated negatively seemed to have even more difficulty finding enjoyment, not only in marriage but in all areas of functioning.

Parenthood. While six of the women had had children out of wedlock who were being reared elsewhere, and one woman had lost custody of her two children through divorce, *none of the children born in wedlock to the women in this study had been placed in foster care*. However, in two homes foster care might eventually be required.

When rated for *social effectiveness* in parenthood, 24 of the 34 women received positive ratings and 10, negative. Eight women were not rated, two because there were no children in the home and six for want of sufficient information.

The criteria for a negative rating were, singly or in combination, a poor quality of physical care of children, severe child behavior or discipline problems, severe parent-child relationship problems.

Again, there were more negative ratings for *sense of well-being* than for social effectiveness. Characteristically, these women *do* better than they *feel* that they do. All of the 10 women rated negatively for social effectiveness were also rated negatively for sense of well-being, and 8 others were also so rated. Only 18 of the 36 women rated received positive ratings. This does not mean that the 18 rated negatively found no joy in motherhood; but they were more worried and less joyous about their children.

For men, the chief indicator of *social effectiveness* in parenthood was providing the primary support of their families. Of those rated, 15 received positive ratings; 2 received negative ratings because their wives were the mainstays of the household. Seven men were not rated since they had no children.

Among the 19 men interviewed, 9 were rated positively for *sense of well-being* in parenthood and 5, negatively. Five were not fathers. As with the women, the ratings depended on their degree of pleas-

ure and satisfaction in their children and their assurance in themselves as parents.

Outside Social Behavior. A person was given a positive rating for *social effectiveness* of social behavior outside his immediate family when there was no evidence that his current or recent behavior in relation to other people had led him into situations disadvantageous to himself or harmful to others. Among the indicators of poor adaptation were antisocial behavior resulting in punishment or ostracism; repeated difficulties with associates, landlords, employers, official agencies; and drinking resulting in job loss or conflicts with associates. On this basis, 17 men received positive ratings; 4, negative ratings; 3 were not rated. Of the women, 38 were rated positively; 2, negatively; 2 were not rated.

Indicators for *sense of well-being* in this area were related to the respondents' satisfaction in social relationships, their pleasure and ease in associating with others, their recreational outlets, the availability to them of confidants, and their reciprocally helpful relationships with others. Twelve men were rated positively, and 7, negatively; 25 women were rated positively, and 15, negatively. This does not mean that those rated negatively felt themselves to be social pariahs, nor that those rated positively were always at ease and invariably experienced adequacy and pleasure in their relationships.

Many of the women were deriving a great deal of satisfaction from relationships with their spouse's family. And there were also some desolate persons who either because of geographic separation or incompatible relationships were not in close contact with any of the three kinship groups with which a former foster child might have connection—his own family, his foster family, and his spouse's family.

Satisfactions were also being experienced in friendships and in group associations, but in varying degrees. Some women rated negatively felt that they must keep their former status as foster children secret lest their associates think less highly of them or ask them pointed questions about their parents. Such an attitude may create wariness and suspicion in a person's dealings with others and a tendency to avoid closeness to people. In contrast, the men and women rated positively seemed to have no such fears or else had developed better defenses against curiosity.

There was a qualitative difference between the men and the women who were rated negatively. The women knew they were being wary of relationships, lacked associations giving them comfort or pleasure,

or were discontent with the amount of their social activities. On the other hand, the men seemed less aware of their restricted behavior and feelings, and, at the same time, were more extreme in the manifestations of such problems. Among them were men whose capacity for pleasure seemed stunted.

Overall scores

Thus the data gathered were in the form of numbers of persons receiving negative and positive ratings within various areas of adaptation. Overall scores for each person were derived by considering all his ratings together.

In regard to social effectiveness, the positive ratings for each area could not be simply added to test hypotheses since persons not functioning in the area of parenthood would be penalized. Therefore, the presence or absence of negative ratings was the basis for dichotomizing the group. The distribution of overall ratings in social effectiveness is shown in Figure 1.

In respect to the sense of well-being, on the other hand, the range of areas of adaptation seemed important in itself. Therefore, the positive ratings were added, the high and low score dichotomy being made between those who had four or more positive ratings and those with three or fewer positive ratings. Thus, a person who was neither living in a marriage relationship nor caring for children could fall within the first grouping only if he had positive ratings in all other areas of functioning. The distribution of sense of well-being scores is shown in Figure 2.

Some associations

During the period of data collection and analysis, it became apparent that the same kinds of ex-

Figure 1 SOCIAL EFFECTIVENESS SCORES

Number of negative ratings	Men	Women
None	15	24
One.....	4	10
Two.....	4	6
Three.....	1	2
Total.....	24	42

Figure 2 SENSE OF WELL-BEING SCORES

Number of positive ratings	Men	Women
Six	4	7
Five	4	7
Four	3	8
Three	4	7
Two	0	3
One	3	7
None	1	1
Total	19	40

riences had had a different impact upon men than upon women. This made it necessary to look at the data for men and women separately, thus introducing a statistical problem of small numbers.

Social Effectiveness and Well-Being. One hypothesis was that social effectiveness and sense of well-being would be associated. While the ratings indicate that these former foster children had more problems with the sense of well-being than with social effectiveness, the data do support this hypothesis strongly for the women and to a lesser degree for men. Of the 22 women with positive ratings for social effectiveness in all areas of functioning, 17 had 4 or more positive ratings for sense of well-being; but among the 18 women with 1 or more negative ratings in social effectiveness, only 5 had high scores for sense of well-being. (Significant at 0.01 level.)

Of the 10 men whose social effectiveness ratings were all positive, 8 had 4 or more positive ratings for sense of well-being, and 2 had fewer than 4. Among nine men with one or more negative ratings for social effectiveness, three had high scores for well-being and six had not. This division is not statistically significant, but if the line demarking less social effectiveness is regarded as less than four positive ratings, a greater contrast occurs. None of the 4 men with 3 or fewer positive ratings for social effectiveness have the higher sense of well-being scores, whereas among the 15 men with 4 or more positive ratings for social effectiveness, 11 were high scores for well-being and 4, low scores. (Significant at 0.025.)

Age and Number of Placements. Another hypothesis was that persons who had been placed in foster

care before the age of 5 would be likely to be more socially effective than those placed later. This hypothesis was not supported by the data either for men or for women; nor was the hypothesis that age of placement would be associated with sense of well-being.

It had also been hypothesized that persons who had been in three or fewer foster homes during their childhood would have achieved better social effectiveness than those who had been in four or more foster homes. The data did not support this hypothesis.

The failure to find an association between social effectiveness and fewer placements was most unexpected. There has long been a general consensus in the child welfare field that frequent replacements are damaging to a child. Moreover, many of the subjects of this study were eloquent in their testimony against replacement, citing the pain and the difficulties in adaptation that leaving one home and going to another had created for them as children.

The data were examined from many angles: "slicing" the groupings as to numbers of placements in several ways; comparing the totals of positive and negative ratings rather than the numbers of persons receiving high and low ratings; relating the numbers of placements to specific areas of adaptation. Frequency of interruption of living arrangements before the age of 5 tended toward a negative effect upon men more than upon women. Nevertheless, the sheer number of foster homes was clearly not decisively associated with quality of outcome.

The same conclusion was reached in regard to sense of well-being scores, although the data tended in the direction hypothesized. Among the 11 men who had been in 3 or fewer foster homes, 8 received 4 or more positive well-being ratings, whereas among the 8 men who had been in 4 or more foster homes, only 3 received high positive ratings; but these differences are not statistically significant. For the women, a division between four or fewer homes and five or more homes showed this contrast, again not statistically significant. Among the 26 women who had been in less than 5 homes, 16 had high positive scores for sense of well-being, scores achieved by only 6 of the 14 women who had been in 5 or more foster homes.

In none of this analysis of numbers of foster homes was the subjects' own sense of loss or gain in the placements taken into account. For this purpose, the data were examined from another angle. Some interview questions had been aimed at securing the subjects' recollections of their foster care. One was: "Which of the foster parents whom you had as a child do you

think influenced your future as a grownup most, either for good or for bad?"

Almost without exception, subjects, in answering, used the term "most influential" to mean "best." Many of the subjects who had been in more than one foster home designated the last as the "most influential." But some did not—in other words, they had been moved from their "most influential home."

These data were examined in relation to sense of well-being scores. Among the 21 women who chose their last foster home as "most influential," 16 had 4 or more positive ratings. Among the 11 who chose a home other than the last, only 3 had 4 or more positive ratings. Among the eight who had only been in one foster home, three had four or more positive ratings and five had the lower scores. (Significant at 0.02 level.) Thus, among the women, the factor of having as a child lost a home which in adulthood is regarded as "most influential" or "best" is indeed associated with an impaired sense of well-being.

This association did not hold true for men.

Hunger and Violence. Another hypothesis was that persons who had experienced hunger or witnessed or experienced violence before placement in foster care would as adults have less of a sense of well-being than those who had not had such experiences.

For the women, the data strongly supported this hypothesis. Of the 17 women who suffered any of these 3 kinds of experiences, only 5 had 4 or more positive well-being ratings. While among the 23 women who had not had such experiences, 17 had 4 or more positive ratings. (Significant at 0.015 level.)

For men, no such association was found.

Out-of-Wedlock Births. The fact of having been born out of wedlock seems to have had a much more damaging effect on the men in the sample than on the women, although inadequacies of data make a conclusive statement impossible. Within the total sample of 47 women, 9 had been born out of wedlock, and 4 of these 9 had themselves had a child out of wedlock, as compared with only 4 of the 36 other women. However, at this stage in their lives, between the ages of 28 and 32, neither those women who had been born out of wedlock nor those who had given birth to a child out of wedlock themselves were different from the other women in levels of social effectiveness or sense of well-being.

Among the 30 men located, 7 had been born out of wedlock. While 21 of the other 23 had married, only 4 of the 7 born out of wedlock had married.

These differences could not be called statistically significant because the sample was too small. Had it been twice as large and the proportions the same, the differences would be significant at the 0.01 level.

The sense of well-being could be scored for only three of the seven men born out of wedlock, and only one of these three received four or more positive ratings. However, information available about the men who could not be rated makes possible the following observations about six of the seven men born out of wedlock, excluding the man who scored high: three of these men had never married; two had been incarcerated more than once for sexual misdemeanors or crimes; two were married to women more than 10 years older than themselves; two of the married men told the interviewer of sexual problems in their marriages; one of the unmarried men had received psychiatric treatment in late adolescence.

The one man born out of wedlock who received a high score for sense of well-being knew the identity of his father and in adolescence had begun using his surname instead of his stepfather's.

Unanswered questions

The foregoing represents only a small portion of the study's findings. As is frequent in research, more questions are raised than answered. One of the most interesting pertains to the apparent difference in impact upon boys as compared with girls of some types of experiences in foster care.

This was an unexpected finding which the research plan was not set up to explore. Were we to begin with it as the problem to be investigated, we would start with the hunch that with girls the content of experiences which reflect upon *what* they are, is of great importance, whereas with boys the kind of experiences which affect their sense of *who* they are, is of greater significance.

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the effects of blindness on children's development

JEROME COHEN



Human beings have a marvelous capacity for adjusting to a major handicap, such as blindness. But many factors can affect the quality of adjustment. This became abundantly clear during a longitudinal, interdisciplinary study of children blind from birth recently completed at the Northwestern University Medical School. The children were tested and observed, by various specialists in the fields of medicine, psychology, and social work, for an average of about 12 years from the time of their birth. Detailed presentations of the medical findings have been presented elsewhere.^{1,2} But some generalized observations derived from the study might be helpful to persons who work with blind children, particularly those handicapped both by blindness and real or apparent mental retardation.

A study of blind children in the Chicago metropolitan area had previously been undertaken by the University of Chicago, and a report of the social and

psychological development of preschool children was presented by Norris and other.^{3,4} Due to the cooperation of the Chicago project and the children's parents, we were able to continue a followup study of 57 of the 66 subjects in the original group.

Eighty-five percent (48 cases) of the blindness within the group was caused by retrolental fibroplasia (RLF), the result of over-oxygenation of premature newborn infants, which was the main cause of blindness among newborns in this country between 1942 and 1955. Other etiologic conditions were congenital optic atrophy, congenital cataracts, retinoblastoma, and congenital absence of retinal receptors. Two-thirds of the group had either no vision or light perception only, and the rest had partial sight but were legally blind.

Retrolental fibroplasia existed far more often in children who had had very low birth weights and consequently had had to remain for many weeks in incubators. Over half of the 43 children with this condition on whom we had original birth information weighed less than 1,360 grams (about 3 pounds) at birth, and 88 percent were kept in the hospital for

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"Human beings have a marvelous capacity for adjusting to a major handicap."

6 weeks or longer. Twenty-five percent were in the nursery for longer than 10 weeks.

Most of this group have caught up with the height and weight norms of their ages; but the lightest prematures have tended to remain small for their ages.

As in other studies of premature births, a much higher incidence of other physical handicaps has been found in these children than is usually found in children with normal birth histories. Those of greatest psychoneurological significance are central nervous system disorders, such as seizures or cerebral palsy, which are found in 17 percent of those who weighed under 1,500 grams at birth.

Intellectual functioning

The group's present intellectual functioning ranges from 45 to 160 on the scale of Hayes-Binet IQ scores. Four children are unable to be tested with any degree of reliability and five are in institutions for the mentally retarded. Of the remaining 48 children for whom we have recent intelligence test data, 18 score below 80 and 12 of those below 70. Twenty-four score between 80 and 120, and 6 above 120. The median score in the group is 93. The distribu-

tion is skewed toward the lower end, but there is a slight piling up of scores at the high end.

The relationship between apparent mental retardation and the degree of vision and prematurity is particularly significant. Fourteen of 27 children, about 50 percent, who are totally blind or have on light perception and who weighed under 1,500 grams at birth have IQ's below 70, whereas about 25 percent of blind prematures with a higher birth weight have such low IQ's. Two out of six cases (33 percent) partly sighted children who weighed under 1,500 grams at birth have IQ's below 70. None of the full term children in our sample are so impaired.

An analysis of the five verbal subtests of the Wechsler Intelligence Scale for Children (WISC) indicates that the average performance on each of the subtests is fairly even, except for "comprehension." The mean for each of the subtests is significantly higher than the mean for "comprehension." This difference holds for all children, both above and below the average IQ of 95. Also significant is the fact that the average-scaled score for "digit memory" is significantly higher in the group with below-average IQ's than the average of each of the other subtests.

According to the logic of the construction of the WISC, there should be no significant mean differences among the subtests. The lower scaled scores for "comprehension" could be due to a lack of social experience, to reduced applicability of the test problems, or to a reduction in abstract capacity of the children. The higher scores on "digit memory" among the below-average group could be the result of excessive emphasis which parents and teachers often place on verbal recall when the blind child plays few other intellectual accomplishments. The measures of intellectual level generally agree with ratings of school performance and therefore appear to reflect the adequacy of personality functioning and adjustment, as well as intelligence *per se*.

The investigators found the WISC verbal scale to be a very good equivalent of the Hayes-Binet as intelligence test for blind children. The correlation between the two sets of IQ's obtained on the tests 0.95—very close to the reliability of either test.

A high incidence of abnormalities was reported in a study of the electroencephalographic (EEG) findings of 28 children with RLF.² It is speculated therefore, that a major correlate of behavioral retardation in these children is neurological abnormality.

The EEG abnormalities were located principally in the occipital lobes, but were often found in mo-

anterior regions as well. Only one case exhibited sharply localized occipital abnormalities and produced an otherwise normal record. The prevalence of generalized high amplitude slow waves is consistent with the hypothesis of rather diffuse cortical damage. Twenty-one children showed spikes in the EEG, but only seven had epilepsy. It would thus seem that whatever brain abnormalities were present had more subtle effects on behavior, generally, than the production of gross seizures.

Two children with epilepsy were also spastic and four others were affected with a variety of cerebral palsy. Two children showed clinical and electroencephalographic evidence of generalized brain impairment in agreement with behavioral observations. One child had a mild neuromuscular deficiency because of poliomyelitis; four other cases showed mild neurological signs, either in exaggerated reflexes or weakness and flaccidity of certain muscle groups.¹

General findings

A consideration of all of the factors with which the study was concerned—from social case histories, medical histories, parents' interviews, and neurological, psychological, and electroencephalographic examinations—leads us to the tentative conclusion that the majority of the children in the study who did not measure up to normal intelligence, and who consequently were not making a satisfactory educational adjustment, were children handicapped by generalized physiological impairments. Only in a minority of cases could we rule out physical factors and place the responsibility for poor development on an emotional basis. But it is difficult to tell what comes first. The parents of an organically impaired child may create emotional problems which obstruct the child's ability to compensate for his handicap.

The "constitution" of the child, for want of a better term, seemed to be the deciding factor in the outcome, if the basic neurological structures were intact.

Behavior problems resulted in children who had had a traumatic upbringing, but in such cases we did not see behavior which simulated physical disability. On the other hand, brain impairment often resulted in low intellectual levels and inadequate adjustment even in families where all other factors were optimal.

We found no convincing evidence that prematurity coupled with oxygenation or blindness itself has resulted in a greater amount of brain damage than might have resulted from the same degree of prematurity itself and the prenatal conditions or possible trauma which contributed to prematurity. However, blindness, especially from birth, so limits the ordinary information flow available to the person that, in the absence of compensatory experiences, the child is not likely to reach the same functional level as he might have done with normal vision.

We have seen children with gross multiple handicaps make good academic progress and develop apparently normal personalities without serious emotional problems. Others either lacked within themselves the motivation and ability, or were too damaged by parental rejection and lack of opportunity for healthy growth.

Some observations

The neuropsychological effects of visual deprivation may be due to impairments in any of three levels of functioning, or to a combination.

The first level is the organic. Impairment here may be due to damage of the brain by events similar to those causing blindness, such as those associated with a very light birth weight or severe illness. It may also be due to the reduction of neural impulses originating in the optic nerves and normally stimulating the brain at many levels. Generalized neurological impairments may limit general intelligence, and resulting learning and perceptual disabilities, with an overlay of emotional instability, may require unique educational procedures. The diagnostic team approach—as undertaken by the psychologist, the pediatric neurologist, the ophthalmologist, and the social worker, and aimed at understanding all the factors in the child's adjustment—is essential for the development of sound recommendations to educational specialists and parents about what the child can achieve through what approaches.

As yet we do not know how the deprivation of sight directly affects the child through changes in the brain's information handling capabilities—whether it is through the biological effects of a low number

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of impulses coming into the cortex, or through the effects of experiential limitations, or as a deleterious overlay of emotional deprivation.

The second level of impairment may be in perceptual integration, due to the direct psychological effect of the absence of visual input, from which most information about environment is normally received.

Vision is the dominant system for perceptual integration. While blind children appear to be highly sensitive to the attitudes of their parents, they tend to be less able to get independent confirmation of the appropriateness of their attitudes from those outside the close family. Blind children usually have endured some degree of social isolation and this, coupled with dependence on verbalization of experience as a substitute for visual integration and the inadequacy of perceptual data for intersensory confirmation of the environment, may lead to emotional problems and inadequate intellectual functioning. The psychological consequences of limitations in perceptual and learning experience when interacting with the consequences of minimal brain damage can produce severe intellectual retardation. However, if the child is able to compensate for his lack of sight by utilizing his other senses, and has experienced healthy emotional relationships, he may achieve a normal adjustment and a normal or even high level of intellectual productivity, despite complicated handicaps.

The third level of impairment is in emotional functioning, and is the secondary effect of the unfavorable reactions from others, especially from the parents, to the visual handicap. This leads to distortions of normal social relationships.

When a mother brings home a blind infant—especially after weeks of initial separation from him because of his need for continued hospital care—she may have difficulty feeling the normal joy and pride in her newborn. Too often she is made to feel the pain and even the “curse” of having a handicapped child, by the expressions of sympathy or embarrassed false cheerfulness of friends and neighbors. Fortunately, many parents of blind children do establish a sound relationship with the baby and learn to love him and enjoy him despite his handicap and other people's reactions. But some parents feel a deep guilt which interferes with their ability to love the child. Others bear the burden of the child as a “cross,” which brings them no closer to real love for the child.

Parental anxiety may result in either of the following damaging attitudes: perpetual overprotec-

tion; or expectation of more from the child than is realistic. Such attitudes, of course, affect the child's emotional growth, for one's self-concept is, to some extent, the internalization of the attitudes of other toward oneself.

Of course, as Allport² points out, it is necessary for the individual at some point to stop being a reflection of the opinions around him, and to form a self-concept based on his actual inner abilities, interests, and strivings. But, to achieve objectivity, requires confirmation of all the senses that the self is an individual, separate, and, to some degree, independent of others. Since vision is the sense which inherently presents the outside world as external, it is instrumental in the natural development of ego differentiation. Fortunately, but sometimes with difficulty, the interaction of the remaining senses in a blind person permits the verification of externality and thus ego differentiation.

Some differences

Differences in the adjustment problems for the child born blind and the child who loses his sight even at an early age lie in both the social and the psychological spheres. Children blind from birth never have to adjust to blindness *per se*, and never have to accommodate to the loss of vision as do older children blinded by illness or accident. But the child who *becomes* blind realizes that he will never see again, and his feelings of hopelessness and despair may cause chronic anxiety and depression.

Blindness from birth may have less consequence for the child's own psychological self-concept, once formed, but children born blind tend to be more affected by other people's attitudes toward them.

Often a child may be educated as blind but have sufficient sight for easy travel and object recognition. We have concluded from our study that any degree of vision is a favorable factor for development, and although we have not the supporting data, that the longer a blind child has had some vision the better. There is no evidence whatsoever that partial sight is a worse handicap than total blindness because of conflict in whether the child behaves as a blind or sighted child. Each “blind” child with some vision who was questioned said that his vision was an advantage and in that way he was better off than his totally blind classmates. For the child who can see objects to be treated as blind may be an annoyance to him, but not a source of deep emotional conflict.

There is often less motivation for the partially

ighted child to learn to use many of the aids for the blind, since to some extent he could depend on vision. This is especially true of training in techniques with which he came for travel. The partially sighted person may learn to rely on his other senses more readily if he is blindfolded during training.

One child with partial vision found it easier to read Braille by sight than by touch. He never got to be a good Braille reader, but the problem was solved by placing him in a class for the partially sighted in which he used books with large type.

Partially sighted children who lose what little vision they have tend to regress in their development. On the other hand, when a child who has been blind from birth has his sight restored by removal of congenital cataracts, he tends to rely upon the more familiar auditory and tactile-kinesthetic cues for a long time. Gradually, as what he sees conforms to his perceptions from his other senses, his vision takes precedence.

Von Senden⁶ reports the case of a girl who for a long time after vision was restored had to stop at the top of a flight of stairs and feel her way down with her eyes closed.

The perceptual distortions reported by many blind people after sight has been restored are mainly due to faulty spatial perception mediated by the non-visual senses. One glance tells the seeing person all the spatial relationships of the objects around him. For this kind of spatial sense is ever achieved by the totally blind, it is by painstaking serial exploration and may never be accurate.

Persons blinded in later life continue to use visual imagery and tend to imagine the world in visual terms, even though the information they receive is from the other senses. Visual imagery retains its organizing function and objects that are located by touch are fitted into the world of visual memory.

The mental picture of the world given in nonvisual terms as it must be to the blind person is beyond the imagination of a seeing person, just as it is impossible to explain to a person who never saw what it is like to see. The words we use are the same, but the meanings are different.

We evaluate the adjustment of the blind to a seeing world. Good general intelligence is the key factor to a successful adjustment, but it may be impaired by emotional problems arising from unsatisfactory affectional relationships with parents and other people significant to the child.

A blind child with neurological impairments faces even greater difficulty, both in adjusting to the social world of human relationships and to the physical world, and in obtaining learning experiences from the environment. However, there is evidence that many children with mild neurological disorders in infancy and early childhood tend to compensate, so that by adolescence little or no evidence of the earlier disability remains. The proper emotional background for a child, enabling him to overcome an impairment and make a good life adjustment, may alleviate the problem; and a deprived emotional atmosphere may aggravate it.

Professional understanding, based on the teamwork of several professions, is necessary for diagnostic evaluation of each child. The many blind children who achieve a satisfactory adjustment and function at an outstanding level of achievement demonstrate the power within human beings to overcome severe physical and emotional handicaps.



¹ Cohen, Jerome; Alfano, Joseph E.; Boshes, Louis D.; Palmgren, Carolyn: Clinical evaluation of school-age children with retrolental fibroplasia. *American Journal of Ophthalmology*, January 1964.

² Cohen, J.; Boshes, L. D.; Snider, R. S.: Electroencephalographic changes following retrolental fibroplasia. *Electroencephalography and Clinical Neurophysiology*, December 1961.

³ Norris, Miriam; Spaulding, Patricia J.; Brodie, Fern H.: Blindness in children. University of Chicago Press, Chicago, Ill. 1957.

⁴ Norris, Miriam: What affects blind children's development. *Children*, July-August 1956.

⁵ Allport, Gordon W.: *Becoming: basic considerations for a psychology of personality*. Yale University Press, New Haven, Conn. 1955.

⁶ Von Senden, M.: *Space and sight*. The Free Press, Glencoe, Ill. 1960.

CHANGES IN SERVICES TO CHILDREN

HELEN R. TIESZEN



In the 10 years since the close of the Korean war, an accelerating trend toward the use of orphanages for the care of children has caused grave concern among many persons involved in efforts to improve the welfare of children in South Korea. According to government figures, 535 abandoned children entered orphanages in 1955; 8,751, in 1964. In these years, orphanages have been the major and sometimes the only means of caring for orphaned and abandoned children.

Now, however, there is encouraging evidence that the trend may be reversed in the next 10 years. Government and private Korean agencies and international service agencies working in Korea are initiating and expanding services to families and children through family planning projects, day-care centers, family counseling programs, better education for social workers, and adoption and foster-care programs.

The orphanages

Before the Korean war, Korea had few orphanages. By tradition, relatives cared for orphaned children. Parents too poor to bring up a newborn child might leave their baby at the gate of a rich man's house where he would be taken in as a gift from heaven and brought up as a son or daughter of the household. The war, of course, disrupted many families and made many orphans. Its close, however, had no effect on the steadily increasing number of children entering the orphanages.

Though relatives still care for many orphaned children, economic conditions are so hard for many Koreans that an orphaned child often represents an unwelcomed extra burden. The few rich families cannot take in all the unwanted babies. Therefore, the orphanages have increasingly become depositories for orphaned or abandoned children.

The policies of both international and Korean agencies in supporting orphanages in lieu of other services have indirectly encouraged some parents to abandon children. In most cases, child abandonment reflects not irresponsibility, but real need on the part of the family for financial assistance and family counseling. Because family services are rare and orphanages are plentiful, indigent parents, to get help at all, have had no choice but to take their child to an orphanage. They are only seeking what most parents want for their children—the satisfaction of the child's basic needs in physical care and education.

The city of Taegu, with a population of 760,000, provides an example of what concentrating attention on orphanages has meant. It contains 51 orphanages and homes for babies, housing 6,886 children; and only 2 agencies which provide family casework services, serving 140 families with 665 children.

The directors of most orphanages are sincere, well-meaning men and women, but most of them lack professional training.¹ Furthermore, orphanages are generally crowded and understaffed; a housemother may care for as many as 30 to 40 children, seldom less

than 15. Several of these institutions do outstanding work, but they cannot duplicate the human relationships of a natural family group. Both government and voluntary agencies, concerned about the quality of care given children in orphanages, have established standards for care and have instituted service training programs for staff members.

A few years ago, the Korean Government, concerned about the increasing number of children growing up in orphanages, ordered the institutions send home those children whose immediate relatives were known. As a result, some children have been reunited with their natural families. However, because basic problems have not been solved, for want of financial assistance or trained workers to provide family counseling, many of the children have later returned to the institutions.

At the same time, the Government initiated programs for adoption a foster family care for children with known relatives to go to, but these programs thus far have not become extensive. According to official estimates, the more than 11,000 children abandoned in 1964, only 208 were placed in foster homes.

Family planning

Among the new methods hold promise for alleviating the acute family problems which result in child abandonment, the present Government places strong emphasis on family planning.

ing. This is a reversal of a previous government position, since programs of family planning were illegal under President Syngman Rhee. In 1962, the present Government inaugurated a 10-year plan with the goal of reducing the birth rate by 2 percent by 1971. The reason for this plan is evident. Korea has made significant economic progress since the end of the Korean war, but not enough to pull ahead of the population growth. In 1962, for example, the economic growth of 2.6 percent was swallowed up by the population increase of 2.9 percent. A large proportion of the population—including most of the families of unskilled laborers—still live in great poverty.

The families of salaried workers—the bulk of the middle class—also suffer great hardship. Though their incomes are higher than the day laborer's, their expenditures for the education of their children, the care of their elderly, and the cleanliness and health of the family are correspondingly higher and are seriously threatened when there are large numbers of children.

Family planning, however, is contrary to the traditional culture pattern of Korea. Until very recently, the family was expected to have as many children, especially sons, as possible. Therefore, progress in family planning is not so rapid as might be desirable from the standpoint of population resource.

Another promising trend for children in Korea is the initiation among a number of Korean agencies of family casework services. Although a few voluntary agencies have long provided financial support to children living in their own families, family service focusing on helping families find solutions to their problems was rare. Among the agencies which have recently started new programs in family self-help and family counseling are several which in the past directed their resources solely toward the support of orphans.

A few day-care centers have been in operation in Korea for sometime, but recently interest has markedly increased in what this type of service can contribute to child welfare, especially in families where both parents work. The Korean Red Cross has done effective work in starting day nurseries in rural areas during the harvest season. Some agencies are experimenting with converting orphanages into serv-

ices such as day-care centers or day schools, in the hope of serving children and their families without cutting the child's ties with his natural family.

Until recently, Seoul has been the only locality in Korea with either a child guidance clinic or a rehabilitation center for handicapped children, both established in the last 10 years. Now, similar services are being established elsewhere by both government and private agencies.

All these efforts are spurred by a Central Child Welfare Committee, established by law in 1961. Made up of top professional people in social work, psychology, law, sociology, and related fields, this group acts as an advisory board to the Ministry of Health and Social Affairs in regard to such matters as child guidance, day care for children, and special programs for children.

New services

In the past, most of the social services have been provided through government agencies and international voluntary agencies. A recently organized multiservice agency, Korea Social Service (KSS), is a new step toward support from Koreans themselves. Though it has a tie-in with the inter-

national agencies, KSS has a Korean board, a professionally trained director who is a Korean, and growing support from the Korean people. Thus it represents a growing concern on the part of professionally trained Korean social workers to become responsible for social welfare programs in their own nation.

Another new service is the result of cooperation between the Government and the international service agencies in Korea, working through their association, the Korean Association of Voluntary Agencies (KAVA). KAVA, established to serve as a group voice and information clearinghouse, has in general not been an action group, though it has sponsored two surveys, one of handicapped children (1961) and the other of grownup orphans (1965). Recently, however, several KAVA agencies and the Ministry of Health and Social Affairs worked together on a project which resulted in the establishment by the Government and international voluntary agencies of the Family and Children Social Work Center in Yichon Dong, an extremely depressed area along the Han River in Seoul. A group of social workers from KAVA studied the area in general and surveyed the needs of families living there before the center was established.

A Korean social worker visits a family in the Yichon Dong area of Seoul in a new program to help families care for their children at home.



The center's services are open to anyone living in Yichon Dong. In June 1965, 186 families were receiving its aid. Because several KAVA agencies are cooperating in its operation, many kinds of services are available to it, including emergency feeding, medical assistance, family sponsorship, casework services, and help with housing. Thus, the center's aim is to help the families work out solutions to their problems in ways that are best suited to their needs and resources. Though the families in Yichon Dong are still very poor, no children from the area have been abandoned since the program started its operation. The whole aspect of the community has changed; there is an air of hope among the inhabitants.

Another new service, established under international agency auspices, is ECLAIR (Eurasian Children Living as Indigenous Residents). Many Eurasian children, fathered by foreign troops stationed in Korea, are adopted outside Korea, but many will never be adopted. The Eurasian child, especially if born out of wedlock, has not been generally accepted as a member of Korean society. ECLAIR aims to achieve the full integration of all children of mixed blood in the public schools and in society at

large. ECLAIR has recently been taken over by Child Placement Service, a semigovernment agency.

Staff development

Several schools of social work have been established since the war. Most of them are staffed by professionally trained instructors and offer good courses in undergraduate study. They train nearly 100 persons a year for social service. However, only Seoul National University offers a graduate school of social work, and it produces only one professional social worker every 2 years.

In August 1965, the central government, in connection with KAVA and the Economic Commission for Asia and the Far East sponsored a 4-day workshop on social work education. The workshop developed recommendations to the Government in five areas: (1) needs and problems, (2) professional education, (3) inservice training, (4) administration, and (5) community organization and development.

Korea is an area of rapid change brought about by the dividing of the country, the Korean war, industrialization, and the impact of Western civili-

zation on its Eastern culture. So old traditions still provide stability but new problems arising from rapid change and the incompatibility between old and new ideas have contributed to social breakdown. The growth of phenomena has been a product of this social change. While it has largely dominated the efforts to serve the victims of social breakdown for the past 10 years, the new trends among both government and voluntary agencies hold promise for more effective prevention and treatment in the future.

¹Alvernaz, Rose; Tieszen, Helen: Technical assistance for child welfare in Korea. *Children*, July-August 1958.

Helen R. Tieszen, consultant on child care training for the Mennonite Central Committee, has been in Korea almost continuously since 1955, except for 2 years when she was on the staff of the Child Welfare Research Station, State University of Iowa.



Guides and Reports

TRENDS IN THE STUDY OF MORBIDITY AND MORTALITY. Public Health Papers No. 27. World Health Organization, Geneva. International Documents Service, Columbia University Press, 2960 Broadway, New York, 10027. 1965. 196 pp. \$2.75.

The 10 papers in this collection discuss the need for statistics on morbidity and mortality, problems in obtaining them, and the methods being followed in developed and developing countries.

HOW TO BRING UP YOUR CHILD WITHOUT PREJUDICE. Margaret B. Young. Public Affairs Committee, 381 Park Avenue South, New York, 10016. Public Affairs Pamphlet No. 373. 1965. 20 pp. 25 cents. Discusses on quantity orders.

Focuses on parents' responsibility to

help their children understand the complexities of human relations in a multiracial society, and to encourage, through example, respect for human dignity and an appreciation for differences in human beings.

PROTECTING THE CHILD VICTIM OF SEX CRIMES. Vincent De Francis. Children's Division, The American Humane Association, Post Office Box 1266, Denver, Colo., 80201. 1965. 13 pp. 35 cents.

Describes community responsibility for providing supportive, protective, and casework services to child victims of sex crimes and their families, intended to protect children from exposure to such crimes as well as to minimize the traumatic effects of the crime and of the legal procedures that follow.

AN EVALUATION SCALE FOR FOUR AND FIVE-YEAR-OLD CHILDREN. Annie L. Butler. Bureau of Educational Studies and Testing, School of Education, Indiana University, Bloomington. *Bulletin of the School of Education*, March 1965. 52 pp. \$1.25 (25-49 copies, 10 percent discount; 50 or more, 20 percent).

A report of the development of testing among nursery school and kindergarten teachers of an instrument for evaluating the maturity level and abilities of children in a preschool class.

COUNSELING PARENTS OF MENTALLY RETARDED CHILDREN. Thomas C. Campanelle. The Bruce Publishing Co., 400 North Broadway, Milwaukee, Wis., 53201. 1965. 7 pp. 75 cents.

A brief guide for professional personnel who deal with parents of mentally retarded children.

ASSESSMENT OF CHILDHOOD DEVELOPMENT

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Since the publication of "The Ego and the Mechanisms of Defense" in 1946,¹ Anna Freud's work has had a profound effect on the professions primarily concerned with the care, health, education, and welfare of children. Her latest work, "Normality and Pathology in Childhood,"² is an intriguing synthesis and extension of her ever-deeper insight and maturing conceptualization of the intervening 20 years. In a field where the complexity of the subject is compounded by the obscurity and ambiguity of its technical vocabulary, Miss Freud has a genius for succinctness and lucidity. "Normality and Pathology in Childhood" can only add to her pervasive influence in the fields of infant care, toddler training, educational planning, well-baby and hospital intervention, social work programs, psychotherapy, and psychiatry. The range of Miss Freud's contributions in this text should excite and interest a wide audience. The point of departure, however, may disappoint the extremists among clinicians, theoreticians, pediatricians, parents, educators, and specialists in child development. Miss Freud readily acknowledges how little we know as yet of either normal or pathological development. She goes backward, for example, to emphasize the point that the child does not live by analysis alone. In fact, Miss Freud sees psychoanalytic treatment of the child as a very serious intervention which must be definitively justified before it is undertaken. She discusses the limita-

tions of conventional, descriptive psychiatric classification, which describes childhood emotional difficulties in the same terms as those used for adults. She points out that the "symptomatic behavior" of the child and that of the neurotic adult have vastly different significance, both developmentally and dynamically; that behavior which may be symptomatic of pathology in an adult may be an appropriate reaction in a child at his age and stage of development. Her discussion on this subject will provide justification for those educators, pediatricians, and parents who from extensive experience have realized the transient nature of many seemingly pathological symptoms.

Miss Freud's documentation of the nature of the child's early instinctual life, his perspective of the world, his dependency, and the limitations of his ego functions is important to assessment both of normality and of expected resistance and other problems in psychotherapeutic treatment. The clinician will also find particularly useful her discussion of the therapeutic problem presented by the highly dependent, often obsessive, child who turns to acting out as a response to the therapist's interpretation of his underlying difficulties.

Her discussion of regression, particularly of ego regression, can be criticized only for its brevity. She distinguishes between: (1) the normality of regression in the day-to-day experience and stress of the child; (2) regressions consequent to defensive impairment of the ego; (3) libidinal-instinctual regressions; and (4) the pathological significance of nonreversible regressions.

Miss Freud brings out a significant change in her view of the nature of the

"transference" in child treatment. The child's dependence on adults who play a significant part in his daily life clearly affects the child's relation with a therapist. This type of transference is to be expected. But Miss Freud now also believes that the child will transfer particular attitudes and expectations to the therapist which reveal the child's fixations and psychopathology. This, she makes clear, is quite different from the transference neurosis which the adult develops during psychoanalytic treatment.

Miss Freud's observation that aggressive energy can be bound, neutralized, or fused with other drives may elicit more controversy than consensus. She seems to use the term more clinically than metapsychologically. However, many clinicians, especially those who work with delinquent children and children with impulse disorders, will appreciate her conceptions of how anger and hatred can be "neutralized" by the growth of libidinal and affective ties; that is, how aggression can become fused and mitigated through the affectional ties to parents and therapist. Her comments suggest an extension of the drive concept, in which libidinal and aggressive wishes and feelings normally are linked with objects, especially with parents, for whom the child usually willingly inhibits his aggression.

Developmental lines

Miss Freud is right, we believe, in her conservative conclusion that we know too little about the vast combinations and permutations which go into making personalities which we may type as "normal."

In assessing the deviations and pa-

¹Freud, Anna: *Normality and Pathology in Childhood: Assessments of Development*. International Universities Press, New York. 1965. 273 pp. \$5.

thology of childhood, clinicians are aware that the emergence of patterns of behavior which are persistent or regressive may signify that a psychopathogenic process is taking place. To assess this process, Miss Freud offers her concept of "developmental lines" as a frame of reference against which particular behavioral manifestations may be evaluated for their maturational progression, fixation, or regression. We suggest that developmental lines are in a sense "culture free" since they are not based on norms which reflect the influence of particular regional or ethnic child-care practices but have to do with the developmental progression of all children—from sucking to eating, from wetting and soiling to bladder and bowel control, from egocentricity to companionship, and so forth.

The clinical usefulness of Miss Freud's concept of developmental lines lies in the assessment of the normality of progressive development and of special problems and regression in a variety of such lines, which are then available for comparison or contrast. Her assessments also improve the clinician's ability to assess a child's drive endowment and development, his ego skills and autonomy, and the nature and strength of his conscience.

Thus, the adequacy of a child's development, if not the "normality" of it, may be differentially assessed from the consistencies and interrelationships of the child's "lines of development." Yet deviations between the lines are not necessarily definitive for the judgment of pathology. Rather, the type of failure of development of the particular child and the degree of deviation between the lines of development are clinically suggestive and determine the need for intervention. For example, preconscious ego skills leading to an advanced line of development may be accompanied by distortions in lines of development related to a degree of dependency requiring correction.

In Miss Freud's view, the purpose of child analysis is not the resolution of the infantile neurosis but intervention to free the child for maturational progress. Clearly, later stages of personality development and increases in capacities are partly a function of the maturational process. Even when there have been some interruptions or failures in lines of development, the innate pressure for growth may provide

healthy solutions to problems that could not be resolved at an earlier stage. Calling this "growing out of it," however, is misleading oversimplification.

Timeliness

The publication of this book in the United States at this time is particularly appropriate, since many parents and professional workers here have assimilated enough of the psychoanalytic concepts to be sophisticated in their use but do not have them balanced off by the conservative experience of analysis to protect them from overinterpretation and pseudanalytic thinking. This has sometimes interfered with effective use of developmental assessments in diagnosis and treatment. In this work, Anna Freud continues an emphasis too frequently overlooked by the incompletely informed diagnostician. For example, she repeatedly stresses the contribution of the child's constitutional endowment to his responses and adaptation to life.

We are, however, somewhat surprised to learn of her readiness to accept the capability of psychometrics to assess intellectual capacity. We note that analytic work has clearly indicated that ego restrictions and ego inhibitions are not always assessable by psychometric means, since the discovery of such processes are frequently obtained only by intensive treatment itself. We are also aware that contemporary research on the patterns of IQ variability indicates that we must be careful in the use or interpretation of IQ scores. Properly used, however, psychometrics remain a useful clinical and research tool.

The timeliness of Miss Freud's latest work is particularly apparent to those of us who are presently concerned with programs of child care and research in connection with culturally disadvantaged, impoverished, pseudoretarded children. The results of such deprivation include a high incidence of severe learning disturbances, impulse disorders, frustration problems, sadomasochistic character disorders, and asocial and antisocial behavior bordering on the psychopathic. Study of such children reveals problems closely paralleling Miss Freud's observations:

... children are referred to the clinics as failures in school, in spite of their good intelligence. In the usual diagnostic examination it is not easy to pinpoint the specific steps in id-ego interaction

which they have failed to achieve, unless we look into them for the prerequisite of the right attitude to work such as control and modification of pregenital drive components; functioning according to the reality principle; and pleasure in ultimate results of activity. Sometimes all of these, sometimes one or the other are lacking. . . .

... That failure in higher ego development . . . results in faulty socialization is borne out by the large number of delinquents and criminals who, on psychological examination, are found to be of primitive, infantile mentality, retarded, deficient, defective, with low intelligence quotients. That dissociation and criminality on the part of the parent, are incorporated into the child's superego by means of normal identification with them has been stressed. . . .

Intellectually retarded children usually suffer acutely from their archaic fear. Due to the immaturity of their ego functions, they lack orientation in and mastery of the inner and outer world alike and the very intensity of anxiety in turn prevents further ego growth. . . .

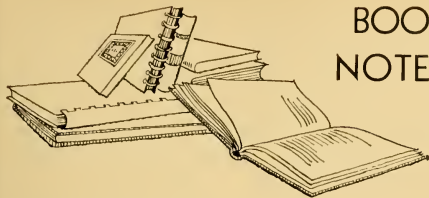
Social policies concerned with retardation, poverty, and delinquency have sometimes been based more on clinical and intuitive insight than on well-documented scientific data. Our methods, attacking these problems are complicated by a lack of understanding of either the gross social problem or of the subtle problems of the individuals involved. We must even struggle with professionally inherited conceptual ambiguities (which we perpetuate). We are faced not only with limited and often questionable social and psychological data, but also with disparities in our scientific theories of normal and pathological development.

In this connection, Miss Freud's contributions have immediate and practical applicability. Her diagnostic profile affords us an opportunity for appraising the culturally disadvantaged child more realistically in terms of his milieu at the extreme stresses with which he lives.

We are sure she would share our interest in learning what is normal and what is pathological in the children of the culturally disadvantaged, as well as our deep concern about the persistence of social conditions which induce pathology in children.

¹Freud, Anna: The ego and the mechanisms of defense. International University Press, New York. 1946. (Written in 1936)

BOOK NOTES



FAMILY. Margaret Mead and Ken Heyman. The Macmillan Co., New York. 1965. 208 pp. \$10.

The collaboration of anthropologist Margaret Mead and photographer Ken Heyman began with their association as teacher and student at Columbia University. Dr. Mead's contribution to this book includes essays on mothers, fathers, families, brothers and sisters, grandparents, the child alone, friends, and adolescents; Mr. Heyman illustrates each essay with photographs of people in aspects of these roles, taken in 45 countries over a 7-year period.

The theme throughout both the essays and photographs is the relatedness of man. Most of the photographs bring out characteristics human beings are in common regardless of differences in color, costume, or custom.

The essays also stress the forces at work for change and their meaning for people in the modern world. In her essay on mothers, for instance, Dr. Mead points out that although the process of civilization "has lightened the woman's physical load," it has in many ways made motherhood a harder rather than an easier task. "A mother, she points out, may find it necessary to put her child into the hands of strangers while he is at work, but she must still love her child unconditionally.

In another essay, Dr. Mead maintains that the grandparents of today are equipped to prepare their grandchildren for innovation and change, a new role which "enables contemporary grandparents to carry out their age-old function of teaching their grandchildren how the whole of life is lived to its conclusion—in the past by running exactly the same course that one's father had run,

and today by a readiness to run each day, each week, each year a new and untried course."

Of brothers and sisters, she says: "... in the modern world, where relatives are scattered and each family lives alone within its own four walls, what one's actual brothers and sisters are like may shape the whole of one's life."

Adolescents she finds in "a surging revolution" to find a "new place in a new kind of world," but warns against pressures that would force them into premature adulthood. Only when young people are given time "to glimpse a wider horizon, a visionary gleam," she maintains, do civilizations leap ahead.

THREE THEORIES OF CHILD DEVELOPMENT: the contributions of Erik H. Erikson, Jean Piaget, and Robert R. Sears, and their applications. Henry W. Maier. Harper & Row, New York. 1965. 314 pp. \$6.75.

In his book, Dr. Maier, a professor of social work at the University of Washington, sets three modern theories of child development side by side: Erik H. Erikson's analysis of emotional development, Jean Piaget's explorations of cognitive development, and Robert R. Sears' experiments with stimulus-response behavior patterns. He summarizes each theory, analyzes their similarities and differences, and discusses the application of each to the helping professions (which he defines at length in a separate chapter). In doing so, Dr. Maier brings a single perspective to these theories of the emotional, intellectual, and social behavior of the child for the use of men and women in the helping professions.

According to Dr. Maier, although each theory has a dynamic system of its own,

each supplements the other two. Each explains the origin of human behavior from a different viewpoint, but all three concentrate on behavior as it unfolds. Piaget and Sears, for instance, deal much less with adulthood than Erikson, and only Erikson considers sex differences as an essential variable. Differences in terminology, Dr. Maier says, are troublesome; the differences, however, can be partly reconciled by considering the intent of the theorists rather than definitions.

In his chapter on the helping professions, Dr. Maier describes the "helping process" as bringing together diagnosis and treatment, observation and relationship, and empathy and rational judgment to enable a "client"—a child with a problem he cannot solve himself—to alter personal conditions. Efforts to help must be aimed at the development process, not at behavior as such.

"... Therapeutic intervention," says Dr. Maier, "... must take into account the phase typically normal of the child's age range, on the one hand, and, on the other, the aspects of other developmental phases that are actually operating in the evolution of the child's personality."

For these reasons, he suggests, an understanding of the three theories and their complementary nature can be very useful to men and women in the helping professions, whether they be teachers, nurses, policemen, clergymen, social workers, physicians, or psychologists.

The book carries a bibliography of general references on human development and its implications for child rearing and guidance, a list of "Further Readings," and an appendix of the complete works of Erikson, Piaget, and Sears.

GIRLS AT VOCATIONAL HIGH: an experiment in social work intervention. Henry J. Meyer, Edgar F. Borgatta, and Wyatt C. Jones. Foreword by Leonard S. Cottrell, Jr. Russell Sage Foundation, New York. 1965. 225 pp. \$5.

This is a report of a 6-year experimental program at a vocational high school in New York City which was aimed at "interrupting deviant careers." The program studied 400 girls identified as having "potential problems." Half, selected at random, served as a control group. The others were referred to the Youth Consulta-

tion Service, a voluntary social agency, which attempted to work with them through individual casework or group therapy. The report follows the girls through their high school careers and evaluates their growth toward responsibility as judged by such criteria as staying in school, getting satisfactory grades, and being regarded by teachers and counselors as showing adequate behavior and work characteristics.

Conclusions, the authors say, are not encouraging. They found that most of the girls selected were in need of treatment but that many did not become significantly involved in the treatment provided. Group work, they found, was somewhat more effective than casework in securing the girls' interest. (Attendance, for instance, was better at group meetings than at individual sessions.) Overall, however, they concluded that the social work services provided were largely ineffective since, according to the criteria used, treatment and control groups were doing about equally well at the end of the 3-year period of study.

The girls showed great stability in attitudes and personality during the experiment. The authors conclude:

"Since the intervention utilized in this project gave more intensive personal attention than is usually provided for such girls, we are lead to suggest that attention to interpersonal and status systems, rather than personality systems, might be more promising."

Mr. Meyer is professor, Department of Sociology and School of Social Work, University of Michigan; Mr. Borgatta is chairman, Department of Sociology, University of Wisconsin; Mr. Jones is senior research scientist, School of Social Work, Columbia University.

SEARCH FOR THEIR FUTURE: our retarded children. John and Dorothy Gayeski, in collaboration with Alvena Burnite. The Bruce Publishing Co., Milwaukee, Wis. 1965. 113 pp. \$2.75.

The knowledge and experience of the parents of two retarded children and a social worker are combined in this book. Mr. and Mrs. Gayeski describe their efforts to find a suitable training program for their own children and then to work for greater understanding of the needs of all retarded children. At the end of each chapter, Mrs. Burnite, a

social worker, comments on their experiences and points up the meaning for social workers and representatives of other professions who have a responsibility to help retarded children and their families. The authors' final plea is for expansion of public and private resources to meet the needs of retarded children, and for increased and coordinated voluntary and official efforts in their behalf.

CHILD DEVELOPMENT: the emerging self. Don C. Dinkmeyer. Prentice-Hall, Englewood Cliffs, N. J. 1965. 434 pp. \$9.25.

In this text by the chairman of the psychology department of the National College of Education, Evanston, Ill. the author emphasizes both the internal growth forces and the external adjustment processes that are related to child's "emerging self," and their interrelatedness. In presenting what he calls "an overview of the entire field of child development," he describes briefly the techniques of child study and various theories of physical, social, intellectual, emotional, and personal development.

IN THE JOURNALS

Negro family life

Three major patterns of family life—patriarchal, equalitarian, and matriarchal—have developed from six social transitions in the history of the American Negro family, according to Andrew Billingsley and Amy Tate Billingsley in the September 1965 issue of the quarterly *Social Service Review*. ("Negro Family Life in America.") The six social transitions referred to by the authors are movement from Africa to America (by force), from slavery to emancipation, from rural to urban life, from the South to the North and West, from negative to positive social status, and from negative to positive self-image.

The patriarchal family, dominated by the father, is usually the elite of the Negro community, according to the

authors, who describe this type as stable and often ultraconservative. The equalitarian family in which both parents share the responsibility for child care and family life is more typical of the middle class, they assert, pointing out that if the father loses employment and so his status, the family structure may change into a matriarchal one.

The matriarchal family, in which there is either no father, a series of fathers, or a weak permanent father, is in the minority among Negroes as it is among other American ethnic groups, but is more prevalent among Negroes than among other groups, the authors maintain, adding that in this type of family the greatest amount of deviant social behavior occurs.

"Efforts to strengthen family life among Negroes seem most fruitful," the

authors say in conclusion, "if they are directed at eliminating the source both the stigma of class and the stigma of caste."

Successive generations of Negroes they maintain, must have the opportunity to become socialized under new conditions.

Finding foster homes

Recruiting foster family homes in the community is difficult but not impossible, says Eudice Glassberg in the October 1965 issue of *Child Welfare*. ("Finding Foster Homes Hard to Find?") may be necessary to revise some traditional methods of providing foster care, however, she adds, if foster homes are to be found. The director of the Foster Home Educational Program (FHEP) Health and Welfare Council of Philadelphia, Pa., Mrs. Glassberg describes the methods used by FHEP to find foster homes for "floating children" (children with no adults responsible

hem), and some of the early results. According to the author, FHEP used every type of mass communication media in the area and distributed brochures through churches, social agencies, and civic organizations to make the community aware of the need for foster homes. It also used 50 volunteers to telephone especially selected potential foster families.

The response was wide, Mrs. Glassberg reports, but in many cases families who made application later withdrew. Many did so, she says, because "they could not accept the idea of only temporary placement." In other cases, the family decided it did not have enough income unless the mother continued to work. Some women offered to give up their jobs to care for children if they could get a like income from the agency.

Mrs. Glassberg maintains that agencies must consider making foster care a paying job. She says:

"When we are clearer about what we need in foster parents, and also clear that we have a right to look for and ask for these qualities—this right being legitimized by our willingness to pay for these qualities—we shall then be able to direct recruiting efforts to more carefully selected groups. . . ."

Punishment and delinquency

Advocates of punishment as the solution of the problem of juvenile delinquency are threatening the protective philosophy of most State juvenile laws, according to Sydney Smith of the Division of Law and Psychiatry, Menninger Foundation, writing in the September 1965 issue of the quarterly *Federal Probation*. ("Delinquency and the anatomy of Punishment.")

While suggesting that the increase in referrals to juvenile courts calls for a reassessment of procedures for handling juvenile offenders, the author maintains that to regard punishment as a cure-all is an oversimplification of a complex problem. Those who do so, he suggests, are operating from one or more of six "false assumptions": all children are alike and can be treated alike; delinquency is an isolated phenomenon; the protective philosophy of juvenile courts has been proved inadequate; treatment costs too much; treatment merely compounds delinquency; and punishment cures delinquency.

The advocates of punishment, the au-

thor suggests, may be punishing themselves, they may be ignorant or afraid of the modern world, or they may have emotional problems.

Also dismissing the sentimental view of those who make excuses for delinquent behavior, Dr. Smith pleads for scientific detachment in handling juvenile delinquents. Delinquency, he maintains, must be neither condemned nor excused, but treated dispassionately and professionally.

Home vision test

More children of preschool age can be reached at home for the testing of their vision than through direct services at public agencies. This is one of the conclusions reached by Roberta A. Savitz, M.D., Isabelle Valadian, M.D., and Robert B. Reed in a study of tests for screening the eyesight of young children reported in the October 1965 issue of the *American Journal of Public Health*. ("Vision Screening of Preschool Children at Home.")

The three authors studied 93 children who lived in public housing projects in the Boston area and who were clients of a child health center operated by Harvard University. They found that the mothers were cooperative and helpful and much more willing to have the testing conducted at home than to bring the children to the clinic.

The tests studied visual acuity, muscular balance, and eye dominance, but only the test for visual acuity proved really effective, the authors report.

Their study began with a look at the activities of the States for testing the eyes of children of preschool age. They found that, although interest is increasing, only a few States have such programs and that these are conducted through clinics and day-care centers.

Another conclusion the authors reached is that the public health service nurse is the person in the best position to test the eyes of children of preschool age, since she can include the test during a regular home visit.

Mother-child separation

The separation of mother and child may be beneficial in some cases, Richard H. Seiden contends in an article in the October 1965 issue of the quarterly *Social Work*. ("Salutary Effects of Maternal Separation.") A

research scientist and lecturer in behavioral sciences at the University of California, Berkeley, he points out that research supports the view that separation is harmful unless there is no other alternative, as well as the view that separation under some circumstances can be beneficial. While law and tradition are against the separation of mother and child, he says, case histories prove that separation may sometimes be better for the child.

It is meaningless, Mr. Seiden maintains, to ask whether separation is good or bad. He is not asking for an "apology" for separation, he says, but for a careful definition of the term.

The author advises the social worker, before reaching a decision to separate a child and mother, to study thoroughly all aspects of the case, such as the quality of previous maternal care, the maturity of the mother, and the quality of substitute care to be provided.

Influence of grandparents

In an article on the influence of grandparents on grandchildren in the September 1965 issue of the semi-annual *Family Process*, Marvin Hader, M.D., reports that some researchers believe the influence of grandparents on grandchildren to be negative, others believe it to be positive, but on the whole, the subject has been neglected. ("The Importance of Grandparents in Family Life.")

Early reports, Dr. Hader says, clearly indicate the possible influence of grandparents on the fantasies of their grandchildren. Some later reports emphasize the value of grandparents in interpersonal relations; while others emphasize the impact of broad cultural changes on the status of older members of the family.

Dr. Hader maintains that grandparents can have a unique and an important influence on the development of children and that the absence of their influence can be harmful.

"The elderly," according to Dr. Hader, "must be made to realize they have a role to play of great meaning and value in our society. They are unique among us in having to accept loss without anxiety as a matter of cultural tradition. . . ." If they accept the loss with grace, "what a gain," and when they can transmit the grace to the young, "what an advance."

HERE and THERE



International

As a result of the receipt of the Nobel Peace Prize for 1965, the United Nations Children's Fund (UNICEF) is establishing a "living memorial" to its first director, Maurice Pate, in the form of a revolving fund to train people in the developing countries in fields of service to children. The prize, 282,000 Swedish crowns, the equivalent of \$54,500, was accepted by UNICEF's present executive director, Henry Richardson Labouisse, at a ceremony at the University of Oslo on December 10, 1965. It will form the nucleus of the revolving fund which will be augmented by the \$5,000 contributions received by UNICEF in the name of Maurice Pate at the time of his death a year ago, and by whatever contributions donors wish to make to the agency for this purpose.

Accompanying Mr. Labouisse at the prize-giving ceremonies in Oslo were three other representatives of UNICEF: Mrs. Zena Harman, chairman of the executive board; Dr. Robert Debré, board member; and Mrs. Adelaide Sinclair, deputy executive director.

The world population increased at an annual rate of 1.9 percent during the period 1960-63, according to estimates of the Statistical Office of the United Nations. The greatest rate of annual increase occurred in Latin America, an estimated 2.9 percent; and the least in Europe, an estimated 0.9 percent. Estimated rates of annual population increase in other parts of the world during these years are: 2.5 percent in Africa; 2.4 percent in South Asia; 2.3 percent in Oceania; and 1.5 percent in North America.

The figures are included in the re-

cently published United Nations Statistical Yearbook for 1964. Sixteenth in an annual series, the book also carries selected social statistics and economic and population statistics for individual countries. Included are illiteracy rates of persons 15 years of age and over, by sex; and statistics on educational facilities, communication media, and professional health manpower—physicians, dentists, midwives, and ratio of population to physicians. The book is available from the United Nations, Publishing Service, New York. (Price: \$12.50 clothbound; \$9 paperbound.)

Child abuse

Grants for four research and demonstration projects on child abuse have recently been awarded by the Children's Bureau. The projects will attempt to determine the causes of child abuse and what preventive steps might be taken on a national basis.

Totalling \$226,345, the grants were awarded to:

- Brandeis University, \$22,159, to investigate reported cases of child abuse in States where there are child abuse reporting statutes. This investigation will be the first phase of a four-part epidemiologic study of child abuse. The other phases will investigate cases of abused children known to the community but not reported under the statutes; use household surveys to find previously unknown cases; and study the effects of community measures to prevent child abuse and to treat families in which abuse occurs.

- The Juvenile Protective Association, Chicago, \$97,120, to establish a protective services center providing a range of services for families in which

children are neglected and abused. The services will include casework with the parents, day care for preschool children, a teaching homemaker, a foster mother, a pediatrician, and a tutor for children having difficulty with school work.

- The Research Center, University of Pennsylvania School of Social Work, \$57,494, to study families after the have received protective services because of child neglect or abuse and to determine the kinds of services most effective in reducing its recurrence.

- The School of Social Welfare, University of California, Berkeley, \$49,571 to study child protective service through (1) a comparison of the personal and social characteristics of parents who abuse their children and those who do not, (2) the extent and kind of protective services provided by public and voluntary child welfare agencies, and (3) the role of the social worker and others who work to prevent correct conditions of neglect and abuse.

Crime and delinquency

In preparation for its report to the President, due in January 1967, the President's Commission on Law and the Administration of Justice has appointed four task forces, composed of experts in judicial, correctional, and law enforcement fields, to study and make recommendations in regard to the four areas mentioned by the President in charge to the Commission: law enforcement; the administration of justice; nature and cause of crime; and correction practices in the United States. Interim reports of the four task forces, which are to be submitted to the Commission in January 1966, will serve as baselines in the Commission's efforts to carry out the President's two-pronged charge: (1) to seek the causes of, means of preventing, juvenile delinquency and crime and to study adequacy of law enforcement and administration of justice and factors that encourage respect for the law; (2) to develop standards and make recommendations for action that can be taken at all levels of government by private persons and organizations "prevent, reduce, and control crime increase respect for the law."

The Commission is composed of members under the chairmanship of Attorney General. They include enforcement officers, present

former public officials, Federal and state judges, lawyers, educators, and a newspaper publisher. Representatives of the Attorney General, the Secretary of the Treasury, the Secretary of Health, Education, and Welfare, and the Director of the Office of Economic Opportunity are working with the Commission as liaison officers.

Unmarried mothers

A recently completed study of 262 unmarried mothers who kept their first-born children, conducted by the Community Council of Greater New York, found that on the whole these women had received few social services either before or after their babies' birth, though they were badly needed. The women were first interviewed in 1962 at the time of their confinement—in 18 voluntary and 13 municipal hospitals—and were followed until their children were 18 months old.

The study also found that the fundamental problems these women were facing were, for the most part, those that confront all poor people—inadequate housing, insufficient education and training for other than the lowest paying jobs, lack of knowledge about where to turn for help.

The study grouped the women by age: under 17, 17-19, 20-24, and 25 and over.

The younger women nearly all lived with and were supported by their parents. Only about half of those under 17 years had returned to school after the birth of their child; very few went to work. Only a few under 17 years were married at the end of the 18 months, and these usually to the fathers of the children.

The older women, on the other hand, or the most part lived alone, with friends, or with the fathers of their children. A greater proportion of them than of the younger women under 17 years were married at the end of 18 months, and a greater proportion had gone to work or had sought public assistance. Most of them were hampered from holding jobs because of lack of day-care facilities for their children.

The report of the study concludes that agencies must reach out to help such women, possibly with totally new services. It suggests a multiservice facility to "provide within a single facility many of the services now frag-

mented through the community"—medical and legal assistance, family counseling, educational opportunities, and instruction in child care. Such a facility, it suggests, might be located in a community with a high incidence of births out of wedlock.

The study report, entitled "Experiences of the Unwed Mother as a Parent," was prepared by Mignon Sauber and Elaine Rubinstein, the director and the senior research associate in the Council's research department. Copies are available at \$3.50 each from the Research Department, Community Council of Greater New York, 225 Park Avenue South, New York, 10003.

* * *

Anticipated difficulties for 80 unmarried mothers who kept their babies had failed to materialize for many of them 3 to 4 years after their babies' birth, according to the findings of a recently completed study carried out under the auspices of the Children's Home Society of California, the Los Angeles County Bureau of Adoptions, and the California State Department of Social Welfare, with Federal funds from the Children's Bureau.

The study, undertaken as the basis of a doctoral dissertation by Barbara Hansen Costigan of the University of Southern California School of Social Work, is the second part of a three-part study on unmarried mothers. The first part, now completed, is a study of the differences between unmarried mothers who keep and those who relinquish their babies; and the third, still under way, is a study of 50 mothers who reversed plans to keep their babies.

The 80 mothers (including white, Negro, and "other" racial groups) were the only mothers available for an interview of the 290 mothers who had left an adoption agency in 1959 or 1960 with a decision to keep their babies. At the time of the study, information obtained on 186 of the 290 indicated that 136 still had their babies with them.

Among the 80 who were interviewed:

- More than half had married and two-thirds of these marriages seemed to the interviewer to be stable.
- Half were not suffering financial hardship (but 32 were judged to be "poor" or in "precarious" financial circumstances).
- None reported being cast off by all their former friends.

• Three-fifths (48) showed no evidence of "maladjustment."

Among the children:

- All but five had mothers who were taking major responsibility for their care.
- Half were growing up in homes with a father, stepfather, or "father figure."
- For a majority (52), child care seemed to be satisfactory.
- Only 10 had not been with their mothers continuously since birth.

The "life of mother and child" seemed to be satisfactory in 46 cases and "questionable" in 34. Mothers in the "satisfactory" group were heterogeneous as to age, ethnic background, educational level, and adjustment at the time of pregnancy.

In reporting on the study, Helen R. Wright, chairman of the study advisory committee, concludes that agencies are in error in assuming that only the exceptional unmarried mother can make a good life for herself and her child, and points to a need for followup services for unmarried mothers who choose to take their babies home.

The report, "80 Unmarried Mothers Who Kept Their Babies," is available from the California State Department of Social Welfare, 2415 First Avenue, Sacramento. (Price: \$1.)

Maternal health

In an effort to protect unborn children from possible congenital anomalies, the Food and Drug Administration recently issued a regulation requiring the labeling of all nonprescription preparations containing the antihistamines meclizine, cyclizine, and chlorcyclizine with a warning against their use without medical advice by women who are pregnant or who might become pregnant. In doing so, the agency pointed out that while there is no proof as yet that these drugs may cause congenital abnormalities in human beings, they are known to have caused such abnormalities in test animals. FDA is continuing to study the effects of these drugs to determine whether additional protective steps should be taken, such as withdrawing the preparations with these drugs from over-the-counter distribution.

FDA has also issued a regulation requiring prescription preparations containing these three drugs to carry, in addition to a warning against use in

pregnancy, a statement that their effectiveness in preventing and treating nausea and vomiting in pregnancy has not been established. Unless substantial evidence of their effectiveness in this regard turns up within the next 2 years, the agency will at the end of this period require that even modified claims of effectiveness be dropped from the labels of such preparations.

According to the policy statement embodying these regulations, the administration of all drugs should be kept to a minimum during pregnancy.

Child health

As a move toward combating malnutrition in small children in the developing countries, the Agency for International Development (AID) and the U.S. Department of Agriculture have taken steps for the flour and cornmeal sent through the Food for Peace program to developing countries to be enriched with calcium, in addition to the vitamin B and iron added to these products in accordance with U.S. enrichment standards. Behind the action are AID estimates that 70 percent of the 667 million children under the age of 14 in the developing countries, where the consumption of dairy products is low, suffer the effects of an insufficient amount of calcium, an essential element in building children's bones and teeth.

The flour and cornmeal enrichment process will be carried out by the Department of Agriculture with funds provided by AID, estimated to amount to \$1 million in the fiscal year 1966. The program is part of a food enrichment program which resulted from a study organized by AID, the Department of Agriculture, the Office of the Director of Food for Peace, and the Bureau of the Budget. Previous arrangements have provided for the fortification of all Food for Peace nonfat dry milk with 5,000 units of vitamin A and 500 units of vitamin D per 100 grams of milk.

Suspected thyroid nodules have been found in school children in Washington County, Utah—an area of high radiation fallout in the 1950's—at approximately twice the rate they have been found in a control group of children in Safford, Ariz., according to a preliminary report of a current study of the possible effects of radiation from the

nuclear tests conducted in the 1950's at the Nevada Test Site. (See CHILDREN, November-December 1965, p. 244.)

In the study, which is being carried out by the U.S. Public Health Service, the Utah State Department of Public Health, and the Arizona State Department of Health and Welfare, 2,000 children were examined in the Utah county, which is near the Nevada Test Site, and 1,400 children in the more distant Arizona control area. Thyroid nodules were suspected, by one or more of the three physicians who examined each child, in 70 of the Utah children and in 25 of the Arizona children. These children were subsequently reexamined by a team of three medical authorities on thyroid glands. Family physicians, parents, and health authorities were then advised when further diagnostic steps were deemed necessary.

In reporting these preliminary findings, the U.S. Public Health Service has warned against drawing conclusions from them before further studies are made. In addition to further studies on the children with suspected nodules, the study is inquiring into the incidence of goiter among their families; where they lived during the 1950's; the state of their health, particularly the condition of their endocrine glands; their dietary habits; and their exposure to radiation of any kind, including medical examinations and treatment. To obtain information on which to base comparisons, PHS is also conducting tests on the thyroid glands of children in other communities.

White House Conference on Health

At the request of President Johnson, 750 men and women, most of them from the health professions, attended the White House Conference on Health in Washington, D.C., on November 3-4, 1965. They came to take a hard look at the Nation's health and to consider ways of improving it. In a statement sent to the participants, the President said that the Conference afforded "a great opportunity to advance ideas which will contribute not only to a healthier America, but to a better world." The viewpoints expressed at the Conference have been transmitted to the President. They touch nearly

every aspect of the Nation's health.

In addition to several general sessions, participants took part in 18 panel discussions focused on three broad categories—education for the health professions, health care, and health protection. Among the comments and viewpoints expressed in the panel discussions were these:

On education. The present method of preparing men and women for the health professions are inadequate. Education and training programs must be reexamined and improved. Incentives to attract more people into the health professions, including people from low-income groups, should be developed. The role of the health team must be more clearly defined as to training, purpose, and effect. Universities must become true centers of medical education and research. We must use to a much greater extent than at present the services of other medical workers and look into the potential of electronic aids to relieve physicians of routine activities.

On care. The results of research are not reaching those who should be using them. Continuous, comprehensive health service should be available to all. Hospitals are behind industry in the effective use of manpower, at steps should be taken to see that hospitals make more effective use of manpower. Health insurance should be improved and extended.

On health protection. The Nation needs more education about health. It must act to conserve its natural resources, combat water and air pollution, and free food crops of vectors and disease pests. Information on birth control should be given as part of routine medical practice to those who desire it. Hospitals should offer family planning services, and social workers should be trained to deal with the problem. Americans must develop a life time interest in physical fitness. Play must be made now for the fruitful use of leisure time by all age groups. Services for the handicapped must be extended and improved, and the public must learn to treat kindly the slightly emotionally disturbed and those released from mental hospitals. More vigilance in the prevention of accidents is necessary, particularly automobile accidents, by better driver education, higher standards for drivers, and safer vehicles.



READERS' EXCHANGE

between poor institutions and good foster homes. . . ." So, let us assume that the research design would, in fact, stipulate an infant-staff ratio of 1 to 1 (ideal), and actually carry this out during the years of experimentation made possible by Federal or other financial support. Is it realistic to anticipate that, should the findings point to positive results, agencies would be able and willing to maintain such an expensive ratio in their ongoing programs?

It should also be recognized that New York City has not really ever gotten a forceful, forward looking foster family care program off the launching pad. However, there are some encouraging signs. For example, one voluntary agency is using case aides to locate potential foster homes, which are then evaluated by trained workers before use. Another has organized its foster parents as a resource for recruiting more foster homes.

If there is a desire to experiment, why not recognize the fact that too many preschoolers are in public shelter care at the present time in New York City, and mount an experiment in which applications for care of infants and young children would be screened, and the children placed either in short-term family care or short-term group care, depending upon both case considerations and research criteria?

Or, why not experiment on a large-scale basis to develop new techniques to locate both short-term and long-term family care in New York City, including the placement of more long-term family care cases outside the city limits?

While I recognize that it may be possible to provide helpful group care to infants and young children, if the physical space, staffing, and other elements are of the best, I seriously question whether the community would be ready, willing, and able to replicate an experiment of this type because of problems of costs and lack of available personnel.

John A. Gabriel
Lecturer in Social Work, City
University of New York

Author's response

It is regrettable that Mr. Gabriel was not in a position to know more about this conference and the subsequent conferences held in New York City at

ago when a voluntary hospital announced some research findings which pointed to the possibility of arresting one type of cancer. Two days later, potential patients were lined up for four blocks near the clinic entrance, seeking the "wonder drug." I am concerned that there might be a similar reaction to an experiment in giving group foster care to young children in New York. Would not this encourage agencies that have been contemplating giving group care to infants to move ahead? And what about those institutions which have been seriously considering changing their present policies of providing group care to infants and young children to the provision of foster family care? Would they be likely to go ahead with their plans?

Then there is the even more important question of whether or not the proposed project would actually be an experiment. While scientific experimentation is important in social work, too many "experiments" and "pilot projects," after several years of "temporary" operations, find their way into ongoing practice, not unlike those children in "temporary shelter care" who end up in institutional care for most of their formative years. Such transformations have occurred even when the experiments have produced inconclusive findings.

I am, of course, being somewhat unfair in attempting to judge the nature of the proposed project without having access to the research design. The report in *CHILDREN* makes the point that "insufficient good care of either type (family or group care) exists . . . (and) too often, comparisons are made

FOSTER CARE: Group care for infants

I am writing concerning the question of experimenting with "group care for infants and young children" in New York City as recently reported in *CHILDREN* and *Child Welfare*. "Conference on Group Care," by Charles P. Gershenson, *CHILDREN*, May-June 1965, p. 120; and editorial, *Child Welfare*, May 1965, p. 244.]

Both journals make essentially the same points: that the country, as a whole, and New York City in particular, are faced with a continuing problem of what to do about the increasing number of infants and young children whose "temporary" care ends up being anything but that. Both also seem to attempt to lay to rest the "debate" of group care *versus* "family care" by indicating that both are needed.

My concern in writing relates to (1) the locus of this proposed experiment, New York City; and (2) the question of whether this will be a true experiment. Both the public and voluntary organizations have labored hard for many years to discourage the institutionalization of young children as a treatment out of desperation rather than a "treatment of choice," with only minimal success. It is a well-known fact that hundreds of preschool children are in group care in New York City—especially Negro children, the largest underserved group. Thus, assuming that the experiment under discussion is in fact to be an experiment, wonder how much thought has been given to the implications of locating it in this particular community?

I recall what happened some years

which more than 50 leaders in the child welfare field discussed their concern about the care of homeless infants and young children in the Nation as a whole as well as the New York City.

The conference in Washington, D.C., focused on the need to develop new modes of infant and child care and the question of whether it is not time to re-examine the possibilities of group care for infants. The next step was the development of a feasibility study to see whether such an examination could take place in New York City.

The New York Fund for Children has recently hired a competent person to direct such a feasibility study. The need for knowing more about the kind of care that can appropriately be offered the many infants and young children who are today left in hospitals and overcrowded shelters is important enough to deserve careful study.

In regard to Mr. Gabriel's comments about the "proposed experiment," I fail to find a single use of the word "experiment" in my own report of the conference. Moreover, it seems to me there is a contradiction in his warning that "experiments" tend to find their way into ongoing practice, for he questions whether agencies would develop similar models if the findings point to positive results. There also seems to be a contradiction in his own proposal for two experiments in New York City after his questioning of the appropriateness of this city for experimentation because of its existing child welfare structure.

There are important questions to be answered and decisions to be made concerning group care of infants and children. We propose only to seek the information that can lead to wise decisions.

Charles P. Gershenson
Associate Director, Division
of Research, Children's Bureau

And a rebuttal

I suggest that Dr. Gershenson overlooked my basic point—there is a great deal needed in New York City in the way of child welfare services—but opening the door to institutionalizing infants after years of effort to prevent the reopening of former institutions for these purposes, or building new ones for infants, does not seem to be one of the needs.

I am not unaware that any researcher "proposes only to seek the

information that can lead to wise decisions." I would suggest, however, that one thing that makes social research tough, and to some of us, interesting, is that you cannot ever start with a "clean slate." A history, attitudes, and experience always predate the research efforts. I was mainly interested in calling attention to these factors.

John A. Gabriel
Lecturer in Social Work, City
University of New York

DYBWAD: A different view

I read with interest the article, "A State Plans for Its Mentally Retarded," by Leopold Lippman, and "A Critique of California's Report on Mental Retardation," by Gunnar Dybwad. [CHILDREN, September-October 1965.]

I would like to take issue with Gunnar Dybwad's critique concerning our recommendation that the Mental Retardation Program Board "serve as a contractor in purchasing services for mentally retarded persons," and that the program board "program assignments and reassignments."

Mr. Dybwad states that these powers are the prerogative of the legislature. It seems to me that this is a sterile and unimaginative response to the problem at hand. Anyone even slightly familiar with the legislative process must realize that legislators do not, and cannot, make the kinds of decisions necessary to provide an individual, flexible, and immediate response to the needs of each one of the thousands of the mentally retarded.

The technique of administrative action followed by legislative review is a more realistic approach to problem solving. This technique was proposed by the California Study Commission on Mental Retardation.

Contrary to the editor's comment in parentheses indicating that the California Legislature balked at granting any of these broad powers, the legislature did provide that the program board would have the power authorized by the joint power provisions of the California Government Code. These provisions permit the contracting recommended by the study commission and permit assignments and reassignments.

In my view, the 1965 legislature adopted without any substantial change the recommendations of the study commission. I hope that other States faced

with this most difficult management problem will not follow Mr. Dybwad's advice in this regard.

Jack Halpin
Chairman, California Stud
Commission on Ment
Retardation, Sacrament

Author's reply

Much as I appreciate the work of Mr. Halpin, whose energetic and imaginative leadership contributed so much to the success of the work of the California Study Commission on Mental Retardation, I must take issue with his assertion that the legislature did not change in essence the commission's recommendation.

According to a legislative progress report from his own office, dated June 22, 1965, the legislature changed the proposed new body into a Mental Retardation Program and Standard Advisory Board [italics mine]. This change goes to the essence of the matter and clearly relates to the point I made.

Gunnar Dybwad
Director, Mental Retardat
Project, International Un
for Child Welfare, Gene

for parents

HELPING YOUR CHILD DEVELOP HIS POTENTIALITIES. R. Strang. E. P. Dutton & Co., N. York. 1965. 256 pp. \$4.50.

BETWEEN PARENT AND CHILD. New solutions to old problems. H. G. Ginott. The Macmillan Co., N. York. 1965. 223 pp. \$4.95.

RESPONSIBILITY MEANS SAFETY FOR YOUR CHILD. Committee on Accident Prevention, American Academy of Pediatrics, 1801 Hinn Avenue, Evanston, Ill. 1964. 23. Single copies free from the academy.

GROWING UP: How we become adults are born, and grow. Karl de S. weinitz. The Macmillan Co., N. York, 10011. Revised 1965 (Fourth Edition). 54 pp. \$2.95.

An illustrated book for children on the subject of procreation, birth, and early growth of animals and people.

U.S. Government Publications

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CHOOSING A HEARING AID. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau; and the Vocational Rehabilitation Administration. CB Folder No. 55. 1965. 12 pp. 15 cents.

Focused on the problem of selecting a comfortable and effective hearing aid for an adult or a child, this illustrated booklet explains how ear specialists and hearing and speech centers can assist by determining the type and severity of the hearing loss and whether the need is for medical or surgical treatment, a specific kind of hearing aid, or a hearing aid plus special training. Basic types of hearing aids are described and illustrated.

FACTS ABOUT CHILDREN'S BUREAU PROGRAMS. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. October 1965. 10 pp. Single copies from the Bureau free.

A brief account of the Children's Bureau programs carried out under the 1912 act of Congress charging it to investigate and report upon "all mat-

ters pertaining to the welfare of children and child life" and under those sections of title V of the Social Security Act, as amended, which provide for grants for child welfare, maternal and child health, crippled children's services, and for related research, demonstration, and training projects.

SELECTED FILMS ON CHILD LIFE. Inez C. Lohr. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 376. Revised 1965. 114 pp. 40 cents.

Superseding the 1962 edition, this catalog lists and describes the contents of 480 films; also includes a subject index and directory of film distributors.

RESEARCH PROJECT SUMMARIES OF THE NATIONAL INSTITUTE OF MENTAL HEALTH. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, NIMH Research Grants Branch. PHS Publication No. 1208. 1964. 59 pp. 40 cents.

The first issue of a projected series of publications which will describe the

major research projects supported through grants from the National Institute of Mental Health. Among other subjects described are inquiries into the relationship of crises to mental health, screening psychiatric drugs for children, how children learn English, and several inquiries into the functioning of the brain.

RESEARCH RELATING TO CHILDREN. Bulletin No. 18 (March-December 1964). Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 230 pp. \$1.25.

This bulletin lists research projects in progress or recently completed which were reported to the Clearinghouse for Research in Child Life from March 1 through December 31, 1964. Subject areas are: growth and development; personality and adjustment; educational process; exceptional children; the child in the family; social, economic, and cultural influences; health services and surveys; and social services.

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children

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THE PROFESSIONS SERVING CHILDREN

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Legal Aspects of Child Abuse

Services for the Retarded

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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The wonder and tenderness in this boy's face are a reminder of children's enormous capacity to spread their love in many directions. But a child's capacity to love at all, if not the child's life itself, may be in danger of annihilation if he is the subject of abuse by adults. What States are doing to protect children from abuse is discussed in the lead article in this issue.

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In recent years, reports of shocking instances of child abuse in court records, professional literature, and the daily press have prompted an outraged public to demand that "something be done." Many States have responded with constructive measures to provide greater protection for children. Sometimes, however, the pressure has been for additional punitive laws, with little attention to the broader legal framework required for effective child protection. It seems pertinent, therefore, to review the general legal framework in which the problem of child abuse is being dealt with in this country and some of the legal and social issues involved.

In the United States, raising children is the business of parents, not of government. Hence, the law normally gives the custody of children to parents, counting on parental love to call forth the care and protection a child requires. The law in every State, however, has provided for intervention by society when parental care is dangerously faulty or insufficient.

Four sets of legal provisions are directly related to child abuse:

1. Provisions of the criminal law, which can be invoked to punish persons who have inflicted harm upon children.
2. Juvenile court acts, which universally provide that when there is evidence of abuse parents or other caretakers may be found to have "neglected" a child and that in such instances the court may institute protective supervision of the child or order his removal from the home.
3. Legislation, in many States, authorizing or

LEGAL PROTECTIONS

AGAINST CHILD ABUSE

MONRAD G. PAULSEN

establishing "protective services" for abused and neglected children as a part of a comprehensive program of public child welfare services.

4. Child abuse reporting laws, now existing in almost every State, which encourage the reporting of suspected child abuse so that the other provisions for the protection of children can be called into play.

The criminal law

The child abuse problem does not require new criminal legislation though legislatures are often led to forget that fact by sensational cases. Murder, rape, arson, assault, and battery, even when committed by parents, are punishable crimes in every State criminal code. Furthermore, existing criminal laws expressly forbid "cruelty to children" in those very words or in a similar phrase. However, State legislatures often forget these facts when the public, stirred up by newspaper reports of sensational cases, demands new, but unnecessary, punitive laws.

In any event, criminal sanctions are a poor means of preventing child abuse. Day-to-day family life, charged with the most intimate emotions, is not likely to be an area of life easily ruled by the threat of fines and imprisonment. A criminal proceeding may punish an offender who deserves punishment but it may also divide rather than unite a family. The criminal law cannot destroy a child's family relationships; it cannot preserve or rebuild them. The most severe cases of

child abuse may call for prosecution, but the prosecutors are not able to arrange for the care a child needs.

A criminal prosecution is a clumsy affair. The proceedings take a great deal of time—for the prosecutor to prepare his case, for postponements to serve the convenience of the defense, the judge, or the witnesses. Guilt must be established beyond a reasonable doubt. Convictions are not easy to obtain because guilt is hard to prove, particularly in child abuse cases since the abuse usually takes place in the absence of witnesses who will testify.

The beginning of a prosecution is likely to be the end of a chance to improve a child's home situation. Parents are nearly always resentful of the proceeding. The hostility engendered makes casework with the child's family all but impossible if the offending parent is still in the home.

All in all, criminal sanctions can do little to help a child. The major problems concern his care and custody.

The juvenile court

In every State, statutory provisions give juvenile courts power over "neglected" children. And in every State, irrespective of the particular legislative language of the juvenile court act, a parent's physical mistreatment of a child is legally a form of "neglect." The neglect provisions, however, vary. Some of the States focus on the behavior of the caretaker: a neglected child is one whose parents "subjected him to cruelty or depravity." Other States stress the child's surroundings: "A neglected child is one who is not provided with a home or suitable place of abode, or

based on a study conducted by the author with the support of a research grant from the Children's Bureau. A full report of the project is in preparation.

whose home is unfit for him by reason of neglect, cruelty or depravity of either of his parents. . . ." Some States simply draw attention to the child himself: A neglected child is one "who is subject to cruel and inhuman treatment and shows the effect of being physically mistreated."

The differences in statutory language are important. The words tell us precisely what evidence is necessary to make out a case of neglect. In States which define neglect in terms of the misconduct of parents, a neglect case can be proved only by adducing evidence of parental involvement. In these States neglect adjudications are not possible in some cases because the injuries cannot be tied to the conduct of the parents, even though juvenile courts in most States only require proof by a preponderance of the evidence, not proof beyond a reasonable doubt. Even in the States requiring only a preponderance of evidence, this must be forthcoming. Situations about which objective items of proof cannot be produced, cannot be remedied in court.

In many cases, however, the judges are overly timid in how they view the evidence. Adjudications of neglect can properly rest on circumstantial evidence. Inferences of parental fault can properly be drawn, for example, from (1) the young age of the victim, (2) the number and nature of the injuries, (3) the place where they were incurred, (4) unconvincing parental explanations, and (5) the fact that the parents were the injured child's custodians and hence in proximity to him most of the time. Not every legal remedy need rest on the testimony of an eyewitness.

A recent opinion of Judge Harold A. Felix of the Family Court of the State of New York is especially significant because he permitted circumstantial evidence to put a burden of "satisfactory explanation" on the child's parents. Denying a motion to dismiss a neglect petition, Judge Felix wrote that the:

... proceeding . . . was initiated undoubtedly by a consensus of view, medical and social agency, that the child Freddie, only a month old, presented a case of a battered child syndrome. Proof of abuse by a parent or parents is difficult because such actions ordinarily occur in the privacy of the home without outside witnesses. Objective study of the problem of the battered child which has become an increasingly critical one has pointed up a number of propositions, among them, that usually it is only one child in the family who is the victim; that parents tend to protect each other and resist outside inquiry and interference; and that the adult who has injured a child tends to repeat such action and suffers no remorse for his conduct.

Therefore in this type of proceedings affecting a battered

child syndrome, I am borrowing from the evidentiary law of negligence the principle of "res ipsa loquitur" and accepting the proposition that the condition of the child speaks for itself thus permitting an inference of neglect to be drawn from proof of the child's age and condition, and that the latter is such a in the ordinary course of things does not happen if the parent who has the responsibility and control of an infant is protective and nonabusive. And without satisfactory explanation I would be constrained to make a finding of fact of neglect on the part of a parent or parents and thus afford the court the opportunity to inquire [sic] into any mental, physical, or emotional inadequacies of the parents and/or to enlist an guidance or counseling the parents might need. This is the Court's responsibility to the child.¹

Statutes which define neglect in terms of a child's environment do not present the same difficulty of proof as do those which address themselves to the parents' conduct. The fact that several injuries have occurred under inadequately explained circumstance can suffice to show that a child's "environment is injurious to his welfare."²

Juvenile court judges have a wide range of powers designed to give the highest practicable degree of flexibility in making dispositional decisions. A judge may warn parents or counsel them. He may order medical or psychiatric treatment for the child or the parents. He may place the child under protective supervision in his own home. He may remove the child from his parents should that extreme step be necessary. The judge also has ample power to act quickly in emergencies; but, unfortunately, a fast judicial response to emergencies may not, in fact, take place because a juvenile court judge may not be readily available.

Another important point is the leeway provided by this wide range of powers. Proof of neglect really involves answering two questions: (1) What real harm happened? (2) Are the "facts" to be characterized as "neglect"? What a judge is likely to characterize as "neglect" will, I believe, depend upon the action which he feels called upon to take.

An instructor in family law, criminal law, and criminal procedure at the Columbia University School of Law, Monrad G. Paulsen is conducting a study of the legal aspects of child abuse under a grant from the Children's Bureau. He is chairman of the Advisory Committee to the Welfare Law Testing Resource of the Columbia University School of Social Work and of the Legal Advisory Committee to the Legal Services Unit, Mobilization for Youth, New York City.



The point to be grasped in Judge Felix's opinion is that he was not contemplating removal of the infant when he entered his judgment. Juvenile court judges surely are affected by a sense that the action taken by the court order must be related to the seriousness of parental unfitness as demonstrated by the evidence.³ A severe spanking by a mother, harassed by the problems of everyday living, might sustain a neglect adjudication if the court were to make the adjudication to expedite further inquiry or to supply social services through the probation staff. It would hardly sustain the judgment if the court were to take the child away from home for any but the briefest period.

Protective supervision

The full use of juvenile court powers can keep a child in his home and still offer protection by providing official intervention into family life. The Children's Bureau has warned that protective supervision should not be allowed to degenerate into mere watchfulness but should be "a purposeful activity directed toward the improvement of the child's situation through the use of established casework techniques and the utilization of other community resources."⁴

However, we should not forget that many families will resent such official intervention. Court ordered protective supervision contains an important element of authority. Therefore, orders of protective supervision, should be periodically reviewed by the juvenile court with a view to termination if the intervention is no longer necessary. Indeed, the New York Family Court Act limits the duration of an order of supervision in a neglect case to a period of year unless "the court finds at the conclusion of that period that exceptional circumstances require an extension thereof for an additional year."⁵

The problem of the juvenile court judges in abuse cases, of course, is to balance the interests of the parents against the likelihood of new harm to the child. No task is more difficult than predicting the recurrence of behavior which can endanger a child. The balancing of interests is made more difficult for a judge who is considering whether to take a child from its parents when under the evidence the degree of parental involvement in the child's injury is not perfectly clear.

Nevertheless, leaving in his home a child who bears the marks of unusual injuries which seem to have been intentionally inflicted is taking a chance with a

child's life. Not all doubts should be resolved in favor of parents. Those who seek a court order to remove a child from a dangerous situation should not have to disprove every plausible explanation for the child's wounds. Temporary removal is not the same as a permanent change of custody. Parents who accept and profit by protective intervention can and do regain custody of their children when new evidence suggests that they are able to care for them properly. Parents have a right to their children, but their children have a right to live.

Protective services

In many States, the law has provided for "protective services" as a part of public programs of comprehensive child welfare services. In addition, some States have granted charters to voluntary agencies to carry out protective services.

Protective services aim at effecting constructive change within the family in which there has been child neglect or abuse so that the child's environment may be improved. A key point is that the offer of services is made as a result of a complaint or referral from someone in the community and not usually at the request of one or both of the child's parents. Some of the parents most in need of assistance would never seek such help voluntarily.

Child protective services are offered without a court order although they may, in some instances, be identical with the services provided in protective supervision ordered by the court.

The Children's Bureau has proposed that a State or local welfare department be required to:

Investigate complaints of neglect, abuse, or abandonment of children and youth by parents, guardians, custodians, or persons serving in loco parentis; and on the basis of the findings of such investigation, offer social services to such parents, guardians, custodians, or persons serving in loco parentis in relation to the problem, or bring the situation to the attention of a law enforcement agency, an appropriate court, or another community agency.⁶

Thus, under proper child protective legislation, a welfare department would be *required* to "investigate" and to "offer social services" to families in cases of alleged child abuse. But the duty does not stop there. The offer of service may be refused. If so, the welfare department can "bring the situation to the attention" of others, including a juvenile court.

In some States, the laws require that protective services be established; in others, the services are merely authorized, leaving the final decision to local

units of government. In any case, if the public welfare agency is to provide protective services to investigate complaints and serve abused and neglected children, the legislature must not only mandate or authorize these services but must also provide appropriations to make them a reality.

The "reaching out" with protective services, whether by a public welfare department or a voluntary agency, presents a problem which the good motives of the agency ought not to obscure. If help is offered when it is not wanted, the offer may contain an element of coercion. There is a danger of overreaching when the agency deals with the most vulnerable members of the community who may easily be cowed by apparent authority. The extent to which the offering of protective services should be reviewed by some judicial or administrative agency is beyond the scope of this paper. Here it is appropriate merely to note the problem. The privacy of a family ought not to be upset lightly.

Reporting laws

Whatever protection the criminal law, the juvenile court, or child protective services can offer to children, it can be offered only in respect to known instances of abuse or neglect. Therefore, statutes which encourage the reporting of suspected cases are an integral part of the law's attempt to protect children.

Bringing suspected cases to the attention of community authorities has been inhibited by many factors. Children, generally, cannot or do not speak out. Neighbors and friends hesitate to make accusations. An abusive father or mother, facile with explanations, often escapes discovery because of the common assumption, "certainly these respectable people couldn't do such a terrible thing to their children."

Over the years, many physicians have failed to alert the community's resources for child protection to suspected cases of abuse. For a number of special reasons they have kept their suspicions to themselves, treated the child for his injuries, and sent him home despite the possibility of repeated abuse. Some physicians have not reported such cases because of fear of civil or criminal liability. Others have been reluctant to play the role of "officials intermeddler," particularly when they might have to face angry parents. Some have regarded reporting as a breach of the special confidential relationship between physician and patient. Some have not reported because

they did not know to whom to report and had no reason to believe that it would benefit the child.

In 1963, the Children's Bureau and The American Humane Association published model legislative language⁷ and guidelines,⁸ respectively, to assist State in drafting laws which would encourage physician to report cases of suspected child abuse. In 1965, the Council of State Governments also published a statutory model for child abuse legislation.⁹

The theory behind these legislative suggestions is simple: Physicians possess the expert skill and judgment for recognizing a case of possible child abuse, a first necessity for bringing an abused child to the attention of the community's legal and social welfare resources. They regularly see cases of injured children and, in some instances, come to suspect that the injuries have not been incurred in the manner described by the caretakers. Therefore, physician should report their suspicions so that the cases can be investigated and appropriate measures taken for the children's protection. The model laws would require physicians to report cases in which abuse suspected, and free them from civil and criminal liability for doing so, and from any legal prohibition against testifying about the case in court.

Few legislative proposals in the history of the United States have been so widely adopted in so little time. During the past 3 years, 47 States passed statutes aimed at increasing the reporting of child abuse cases. At the beginning of 1966, only Hawaii, Mississippi, Virginia, and the District of Columbia were without such laws. This remarkable record has been achieved largely as a result of the publication of the proposals of the Children's Bureau and The American Humane Association, and of the wide publicity given the problem of child abuse in the medical and social work literature as well as in the mass media, including a drama in the "Ben Casey" TV series.

The proposals for reporting laws present a number of legislative issues, and as the 47 legislatures have tried to resolve them they have produced statutes with a great many differences.

All the State laws protect physicians against liability for reporting, although in Wisconsin legal immunity is provided only from criminal liability. In the six States where the statutes do not impose a duty to report, the extension of legal immunity is the only effect of the law aside from whatever encouragement to reporting may come from the passage of the legislation and the inclusion of the reporting section in the statute books. The statutes in these six States

and a 1965 proposed statute drafted by the Office of the General Counsel of the American Medical Association¹⁰ reflect a view held by some physicians that, for professional reasons, doctors should be allowed to retain some discretion in reporting. Other physicians, the American Academy of Pediatrics, and 41 State statutes support mandatory reporting.

A mandatory requirement for reporting can be of great assistance to a physician in explaining his decision to protesting parents. But there is another point in favor of a mandatory law. Whether cases of suspected abuse should be brought to the attention of the authorities responsible for child protection is not a medical question, but a question of social policy, properly answered by a legislature.

All 47 reporting statutes designate physicians of all kinds, and most of them also designate hospitals, as reporting agents. Some statutes and the American Medical Association's proposal reflect a judgment that the laws should also encourage reporting of suspected child abuse by members of other professions who see children regularly, such as nurses, dentists, teachers, and social workers. A few States provide that everyone who suspects a case of child abuse is covered by the statute.

The argument for focusing on reporting by physicians is very strong. Doctors face special confidentiality problems arising from the physician-patient relationship and are concerned about the threat of legal action. Actually, the chief aim of the legislation is to uncover cases which only medical skill can detect in the course of a medical examination and a review of the medical history. The obvious cases of maltreatment are likely to be identified by persons in the community who, at least in cases of serious injuries, bring them to the attention of some authority or agency which can take action. If the statute's reporting group is large, the impact of the reporting requirements may be diffused. Everybody's duty easily becomes nobody's duty.

Recipients of reports

The Children's Bureau proposal of 1963 recommended that reports of suspected child abuse be made "to an appropriate police authority." The police authority was designated originally because it "constitutes the only chain of services which is sure to exist in every community."⁷ Moreover, police are available 24 hours a day.⁷

On the other hand, The American Humane Association has recommended that suspected cases be re-

ported to the public or voluntary child welfare service which carries the child protective function in the community.⁸

Because, since 1963, public child protective services are becoming more widely available as part of comprehensive child welfare programs in the States, the Children's Bureau now recommends that in communities where a public welfare agency offers child protective service it be the agency designated to receive reports.

The 47 State statutes vary greatly with regard to the agency designated to receive reports. Some designate the police, another law enforcement agency, or the juvenile court. Some designate public or voluntary child welfare agencies, or both. In many States, more than one type of agency is designated.

The designation of the police or other law enforcement authority as the recipient of reports creates all sorts of problems. The investigative skills of the police, the sheriff, or the prosecutor are useful in answering the question, "Who did it?", but they are not likely to be of much use in answering: "Why was it done?", "What can be done to preserve the family?", or "How can this child be protected?" Law enforcement officers habitually look for a basis for prosecution, but are often blind to danger signs present in a home situation which would be apparent to a properly trained social worker. Investigation by a law enforcement agency is likely to engender defensive hostility in the parents and make successful intervention by a child welfare worker impossible. The child protective service of a child welfare agency possesses the greatest fund of desirable resources to focus on what happens to the children involved.

There is a growing trend, as evidenced by the statutes adopted or revised in 1965, toward the designation of the public welfare department either as one of the agencies to receive reports or as the agency to carry the chief responsibility for making the initial investigation following a report.

If reports are to be made exclusively to public welfare departments, however, some provision should be made to provide for round-the-clock emergency service. Illinois has initiated a unique system of statewide emergency service which can be reached by calling a well-publicized telephone number.

Statutes which provide a choice of agencies to receive reports in the same community bring uncertainty to administration and confusion to those who are obligated to report. Worst of all, none of the designated agencies may have a clear responsibility for action. Of course, a State may find it necessary

to designate different agencies as exclusive recipients of reports for different parts of the State. Resources available in one community may be absent in another.

In two States, California and Illinois, under the provisions of State law, and in a few cities, for example, New York, under local administrative regulations, reports of instances of suspected child abuse are recorded in a central registry. Parents who abuse their children sometimes go from doctor to doctor and hospital to hospital in an attempt to escape attention. A central registry helps to identify these "repeater" cases, and can help determine the significance of the present injury. Knowledge of a previous report of suspected abuse can help confirm suspicions that an injury is the product of abuse.

A central registry also serves an important statistical function, which can lay the basis for learning more about the nature and causes of child abuse. Some State and local welfare departments collect information for statistical and research purposes only, without making specific case information available to physicians and social workers.

Some questions about the effectiveness of reporting statutes probably never can be answered. For example, we cannot prove that reporting laws actually cause more cases to be identified than before. Records of casefinding were not previously kept. And, we do not know how many abused children, if any, are deprived of medical attention because their caretakers are afraid of being reported. Such cases are not recorded.

Nonetheless, the facts at hand provide a compelling argument that reporting laws are having an important impact. First, reports are being made under the statutes and in increasing numbers. Dr. David G. Gil of Brandeis University, director of a nationwide epidemiologic study of child abuse,¹¹ estimates that approximately 5,000 cases will be reported under these statutes alone in 1966. In the first year under the New York State reporting statute, reports involving 424 children were received. In the second half of the year, the rate of reporting increased.¹²

The reporting legislation has spurred the establishment of new public services aimed at child protection. In some States new legislation has been passed requiring or authorizing child protective services, and in others additional services have been provided under existing laws. In some States, after a reporting statute has been passed, legislators have made additional money available for child protective services.

Legislation alone does not bring reporting. In some places where the child abuse reporting laws have been most successful a burst of cooperative activity has taken place. Newspapers, medical societies, and welfare departments have alerted the citizenry and the medical professions about the reporting statute. Hospitals have established regular channels for reporting cases, and communities have created the machinery to help physicians comply with the law.

Reporting is, of course, not enough. After a report is made, something has to happen. A multi-disciplinary network of protection needs to be developed in each community to implement the good intentions of the law. If child protective services are not available, reporters will no longer report. The promise of casefinding legislation, such as reporting laws, is that when a case is found, something is done about it. The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children.

¹ *In the Matter of S. 259 N.Y.S. 2d 164 (Fam. Ct. 1965).*

² National Probation and Parole Association (now National Council on Crime and Delinquency): Standard juvenile court act, sec. 2(B). New York. 1959.

³ Paulsen, Monrad: The delinquency, neglect, and dependency jurisdiction of the juvenile court. *In Justice for the child.* (M. K. Rosenheim, ed.) The Free Press of Glencoe, New York. 1962.

⁴ U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.

⁵ New York Family Court Act, sec. 354.

⁶ U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Proposals for drafting principles and suggested language for legislation on public child welfare and youth services. 1957. (Multilithed.)

⁷ U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: The abused child—principles and suggested language for legislation on reporting of the physically abused child. 1963.

⁸ The American Humane Association, Children's Division: Guidelines for legislation to protect the battered child. Denver, Colo. 1963.

⁹ Council of State Governments: Program of suggested State legislation. Chicago, Ill. 1965.

¹⁰ American Medical Association: Physical abuse of children—suggested legislation. Chicago, Ill. 1965. (Micrographed.)

¹¹ Gil, David G.: Epidemiologic study of child abuse—research in progress. Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. 1965.

¹² Report of the New York State Department of Welfare, Albany Nov. 30, 1965.

The variety of approaches that can be taken toward improvement of services for the retarded are suggested by the following two articles which describe, from different perspectives, some of the many innovations that have been taking place within one State.

improving an institution's services for the retarded

OWEN E. FRANKLIN

DONALD J. BAKER

Public institutions for the mentally retarded have long been handicapped by shortages of professional workers, limited funds, overcrowding, long waiting lists, and isolation from the mainstream of society. Paradoxically, they have been constantly pressed to admit more patients and at the same time to improve their services. Confronted with these problems and with the growing public interest in the quality of programs for the mentally retarded, many such institutions have been searching for solutions which would help them not only to improve their intramural services, but also to integrate them with an overall community program for the retarded. Woodward State Hospital-school at Woodward, Iowa, is among them.

Woodward is one of Iowa's two State institutions for the mentally retarded. Five years ago, the institution was so overcrowded that in some of the wards beds were lined along the wall flush with each other with no space between. A long waiting list was growing steadily as individuals and communities waited for priority for their candidates. Numerals, often conflicting, calls about particular children waiting admission created confusion in admission practices. Community-based services for the mentally retarded were sparse and uncoordinated.

Sadly lacking in the institutional program were: (1) sufficient attention to differential planning and programming for the patients on the basis of individ-

ual diagnoses; (2) clear admission and release policies; (3) planned preadmission and aftercare services; (4) strong ties with the outside community; (5) sufficient professional personnel of all types. For example, the institution's seven-member social service department included only two persons with master's degrees in social work—the director and the social service supervisor.

In 1961, the institution began a unified effort to improve the quality of its services, reduce both the patient load and the waiting list, and become an integral part of a many faceted State and community program for the retarded. In this effort, it had the backing of the Iowa State Board of Control of State Institutions which had recommended that the institutions for the mentally retarded adopt a 4-point program to (1) transform the two institutions to specialized treatment, training, and care centers; (2) cooperate in the development of adequate extramural services; (3) develop inservice training for all types of staff; and (4) encourage research into clinical and administrative practices.

Involving the entire staff, the institution's effort to revitalize its program proceeded through two main lines of attack: (1) devising methods for the more effective use of professional and auxiliary staffs; and (2) keeping the staff, and hence the institution and its patients, in closer touch with the outside community. Today, the institution has about



A multidisciplinary team at Iowa's Woodward State Hospital-School discusses a plan for a patient's treatment and care.

1,000 resident patients as compared with nearly 1,700 5 years ago, and its waiting list has been abolished. What is more important, its patients, both inside and outside the institution, are receiving more of the kind of attention they need to help them function at their best.

This article will focus on the role of the social service department in these developments. However, since this role was closely integrated with the entire revitalization program, a brief description of the framework in which it has been carried out is pertinent.

At the beginning, the administration decided that the institution, which consisted of 37 buildings, including 13 residences for patients, would be divided into 4 administrative areas and that an interdisciplinary team would be set up to serve the residents in each area. Each team would consist of a physician, a psychologist, a social worker, an educator (academic or vocational, depending upon the ages and needs of the residents in the area), a chaplain, a recreation worker, a ward attendant, and a representative from Nursing Attendant Service. Previously, the professional members of the staff had their offices in a central administration building, far removed from the residential buildings. Now each team office would be located within the area of the institution for which the team was responsible, thus putting the clinical staff in regular touch with the residents and

so providing more opportunities for interaction between them.

The plan was for the teams to begin to work immediately on a "crash" program of evaluating the functioning level and potential of each resident and to follow each evaluation with habilitation service according to individual needs. One of the purposes was to determine which residents had needs that could best be met in their home communities and which needed further training or care within the institution.

While this program got under way, the new administration assigned staff members to a preadmission evaluation clinic and named the director of the hospital's social service department as chairman. Other staff members of the clinic included a physician, a psychologist, a director of nursing, the director of the institution's education and training department, the registrar, the chaplain, and the social service supervisor. The purpose of this clinic, which replaced the institution's previous diagnostic clinic, was to provide the kind of selective admission process which would enable the institution to furnish a specialized program of training and education to its residents.

In order to carry out this overall plan, the administration set up a clear-cut salary budget for each department designed to attract more professional workers to the institution and to reduce staff turnover.

Social service priorities

At the time of this reorganization, the administration delegated to the social service department several specific responsibilities: major responsibility for determining who is admitted; strengthening ties with communities; arranging for the return of patients to their own communities on the basis of a decision by the area team; and participating in the intramural team staffing arrangement. This meant new and greatly increased responsibilities for a department which had heretofore largely confined its efforts to interviewing parents of the patients, writing case histories, corresponding with relatives, and finding jobs in the community for some of the higher functioning residents. The department would now have to address itself to two broad objectives:

1. Offering individual services to deal with the social, emotional, and environmental problems of patients and their families, before, during, and

after the patient has been placed within the institution.

2. Fostering and maintaining a constructive relationship between the institution and the community to help the community bring about more nearly adequate social services for the retarded.

Obviously, making the best use of all available staff members would be the key to the department's effectiveness, and in this effort the clear-cut salary budget would be a great help.

As a basis for a logical consideration of its personnel needs and uses, the department established the following specific goals, in order of priority:

1. Participate in the evaluation of all the residents.
2. Contribute to strengthening the preadmission evaluation process.
3. Recruit additional persons for the staff.
4. Initiate a series of meetings with the county board of supervisors in each county served by the institution, as the Code of Iowa places administrative and financial responsibilities on this body for the care of the mentally retarded at the county level.
5. Promote an organized release and aftercare program.
6. Improve social services within the institution.
7. Provide inservice training and other means of development for the department's staff.
8. Conduct service-related research.

The department then initiated an intensive recruitment program to secure the type of manpower commensurate with these goals—social service representatives to work full time outside the institution, community consultants and social service representatives to work in the institution on the professional teams. Simultaneously, the department initiated communication with the county boards of

supervisors to pave the way for future meetings between representatives of the institution and the boards to discuss ways in which the institution and the county boards could work together in the interests of the mentally retarded. At these meetings, the institution offered its consultation service to the counties.

The needs of patients, the institution's budgetary limitations, and the shortage of graduate social workers, considered together, resulted in a plan to have two levels of social service staff—persons with graduate degrees in social service and persons with bachelor's degrees only. This plan emphasized the importance of having a good and continuous staff development program.

Research activities, it was decided, would have to be developed later and directed primarily toward the study of factors bearing upon the development of the community services program.

Assessment of client needs

The next step was to determine the deployment of the department's staff to provide the best social service coverage possible within its means. This meant defining the tasks involved and determining which required the skills of a graduate social worker and which could be performed under professional supervision by a person without formal social work education. To do this, it was essential to determine the needs of the department's many types of clients. These included (1) the communities of 48 counties; (2) the retarded people in their populations; (3) the various agencies which could serve the retarded; (4) the institution's residents and their families; and (5) the professional teams.

In the communities, local agencies, such as the county welfare department, the public health nursing service, the schools, the courts, and the associations of parents of retarded children, needed a helpful relationship with someone who had knowledge of mental retardation, the State and national resources for dealing with the problem, and the roles of the family, the institution, and the community in meeting the needs of the mentally retarded. They needed to know that the institution's policies in relation to their county would be based on an individual assessment of the county's resources. They needed an opportunity to express freely their attitudes toward the institution, its program, and its policies. And they needed someone to help stimulate more effective cooperation among social, educational, medical, and

th Owen E. Franklin, left, and Donald J. Baker write of Iowa's Woodward State Hospital-School out of experience in its social service department. Mr. Franklin is director of the department before coming to the Children's Bureau in 1964 as specialist on social services to mentally retarded children. Mr. Baker, presently assistant director of the department, joined its staff in 1961 as social service supervisor.



citizen groups and the agencies in the locality.

The patient, on his admission, needed at least someone to help acclimate him to a strange, large, relatively impersonal institution—someone to tell him about what might happen to him, help prepare him for its programs and services, and help him feel accepted. Above all, he needed emotional support and assurance that his family or someone still cared for him and about what happened to him. Later, if he were to leave the institution for home, temporarily or permanently, or to be placed in another community facility, he would need preparation for the change.

The parents of the patient needed someone to help them deal with the many problems they would face during the admission process and to keep them informed of their child's progress in the institution. They needed assurance that the institution was interested in the family and was willing to help them maintain contact with their child, and they needed to be drawn into the planning for the aftercare of their child.

The professional teams, with responsibility for the specialized treatment, training, and care of the residents in their respective areas of the institution, needed to be kept aware of developments within each patient's family and the resources available to him in the community. They needed to know the kind of family conditions or substitute care to which the patient would go, if recommended for release.

After thus analyzing the needs of its clients, the department assigned the community work to its staff members with graduate social work degrees, because functioning effectively as a community consultant implies a high degree of autonomy and requires a variety of social work skills. Staff members with bachelor's degrees only were assigned as social workers on the institution's area teams to work under the close supervision of the social service supervisor and were provided with a continuing program of inservice training.

The community worker

The three community consultants each spent about 3 months in the institution to become oriented to its programs and objectives. They attended the area team meetings and participated in regular discussions with the administrative staff about their community responsibilities.

The social service director then arranged with the county boards of supervisors for an introductory visit from the consultants to be assigned to their

counties. At the conclusion of each of these initial meetings, the county board was requested to designate a county employee to provide liaison with the institutional community consultant in planning for the mentally retarded. This they did, and the person so designated, usually the director of the county welfare department, came to be known as the "county designate" and became the focal point for merging community and institutional interests in the mental retarded. From then on, the community consultant worked through the county designate's office to involve the health, education, and social agencies in the community in individual case planning and community program development. The community consultant offered help in case planning whether not institutionalization was being considered.

Each community consultant lives within the group of counties he serves. His office is his home.

Among the consultant's specific activities are:

- Establishing a working relationship with the county boards of supervisors and their designate and with other community leaders as necessary, coordinate case-by-case planning for the mental retarded both in and out of the institution.

- Helping county designates understand the needs of retarded people and the implications of specific methods for meeting them.

- Helping the county designates and other interested persons understand the emotional factors associated with mental retardation.

- Demonstrating methods of dealing with social emotional factors in specific cases.

- Studying local communities to find resources for the mentally retarded; suggesting ways of using them more effectively; and stimulating the development of new programs.

- Stimulating a cooperative approach to problems at the community level.

From the beginning, the department recognized that the community consultant might be exposed to resistance, misunderstanding, and outright antagonism. Some of these negative reactions would be based on actual past experiences with the institution, some, on a preference for local, as opposed to State programming; some others, on resistance to the new preadmission and release policies; and still others on a reluctance to develop new services at a time of high costs. Hence, an opportunity was provided staff members, "on the firing line" in communities, to spend at least 2 days a month within the institution to consult with the administrative staff and to

members individually and in meetings. They were also brought into the institution at intervals to substitute for the social service supervisor or the director of social service in order to help them maintain their continuity with the institution and to develop professional versatility. While working in their communities, the consultants were encouraged to telephone the social service department whenever they felt the need. They sent in regular narrative reports of their activities, findings, and impressions. Further, they were encouraged to attend various professional meetings in the State, and each year one consultant was selected to attend an out-of-State meeting on a topic related to the institution's work.

Area team social workers

As vacancies occurred rather quickly among the undergraduate social workers who were already on the staff, their positions were filled by recent college graduates interested in careers in social work. These recruits were selected for their apparent warmth and concern for people, their interest in mental retardation, and their flexibility.

The new team social workers spent the first months so in an orientation program in the administration building, which included instruction and job assignments under the close supervision of the social service department. During this on-the-job training, they attended meetings with the teams to which they were to be assigned as well as with other teams. Thus, theory was immediately combined with practice.

After their assignment to their area teams, they remained under the supervision of the social service supervisor and continued to attend staff meetings with the social service staff, the community consultants, and the administrative staff. They had ready access to the social service supervisor or the director for assistance in handling their work assignments. As a member of the professional team, the team social worker contributes information about the resident, his family, and the community to the other team members. In addition, he carries out the team's recommendations related to the social service department's responsibilities. Some examples of other tasks performed by team social workers are:

• Interviewing parents, other relatives, and guardians in regard to the resident's progress, referral to other agencies, and tangible needs such as money and housing.

• Serving as liaison regarding specific patients between the team and local agencies, parents, and other interested persons.

• Serving as liaison between the team and the social service department.

• Conducting individual tours of the institution for parents of prospective patients.

• Helping prepare new residents for their stay at the institution, providing them with a supportive relationship while they are there, or preparing them for release to their own homes or to community facilities.

These tasks were assigned to college graduates without social work training. The contacts with patients and families they involved were brief and concerned only with tangible needs. The department realized that many patients and their families needed intensive social casework of a kind the team workers were not able to supply. However, the tangible services of the team social workers were important to both residents and their families. The addition of more intensive service remains a goal for the future for the institution.

In addition to having an "open door" policy for the team social worker, the social service supervisor scheduled weekly conferences with each one. After the new program got well under way, the department initiated a series of bimonthly seminars to introduce

A retarded boy, with adult guidance and understanding, learns the simple but useful skill of lacing a shoe.



social work knowledge, attitudes, and skills. Subjects discussed in the seminars included principles of interviewing, recording, social work methods, human growth and development, professional development, and public welfare. Lectures on mental retardation by staff members of other departments were also included in the seminars. The team social workers were encouraged to use the new professional library being developed within the institution and to attend social welfare meetings held by various organizations within the State.

Some results

In the 5 years since the inauguration of Woodward's unified effort to improve its services, and the resultant expansion and reorganization of its social service department, the institution has experienced a noticeable acceleration of turnover in its residential population—an important indication that it has been accomplishing at least some of its objectives. For example, only 34 patients had been admitted in 1960, because space was not available for more. In 1964, the number of admissions had quadrupled to 136. Yet, in spite of a steady increase in admissions, the number of residents was reduced to 1,010 by July 1, 1965, as compared with 1,648 on July 1, 1961. Full discharges increased from 153 for 1960 to 204 for 1964. The residents on leave within various community facilities—own homes, foster homes, group custodial homes, and nursing homes—increased from 192 in 1960 to 596 by July 1, 1965. And, as already mentioned, the waiting list for admission has been eliminated. Nevertheless, all plans for admission or release have been worked out on an individualized basis involving parents and community agencies.

Behind these developments lay hour upon hour of ponderous effort by the institutional staff in working, case by case, with local agencies (which were sometimes suspicious of the institution because of past experiences) and with parents who often viewed their child's institutionalization as the "end of the line."

Undoubtedly, one of the most important results of this effort is the partnership formed between the institution and community agencies for developing local services for the mentally retarded and their families. Because the original three community consultants are still on the staff, the relationships between institution and the outside world have retained continuity—relationships which are born of mutual involvement with local people in connection with real

cases and with the needs of the community.

The social service staff development and supervisory arrangements have not only helped hold staff members with graduate degrees in social work but have also helped enlist recent college graduates into social work. There has, however, been a complete turnover of staff members with bachelor's degrees only, although all who have left have expressed satisfaction with their experience in the institution. Of the first five who left permanently, three went on to graduate training in social work; one took other employment in a hospital social service department; one her home town; another left to get a master's degree in a related field, special education. Another worker left to attend a school of social work on a stipend provided by the institution and since graduating has returned to the institution to work.

Reduction of the institution's population was as important as increase in staff in improving professional services, for this reduction also brought about a better staff-resident ratio. Residents are now evaluated thoroughly twice each year for the adequacy of the programs or needed change. The fluidity of movement of patients to and from the institution makes it possible for the institution to provide its patients with a truly dynamic program of training, treatment and habilitation.

These efforts to improve Iowa's services for the mentally retarded may have much broader significance than the accomplishments in the program for which they were devised. They were a conscious attempt to try out ideas which have been discussed widely in recent years among persons concerned with services to the retarded, for example: to use two educational levels of social service staff in different ways; the deliberate plan for making the institution a part of a continuum of resources for comprehensive care through the provision of the community consultant; the use of the mental retardation specialist to help the generalist—and again through the community consultants working with the employees of local health, education, and welfare agencies; and the establishment of a referral point in each locality for problems concerning mental retardation—the county design backed up with consultation and service from the community consultant.

Above all, the institution's experience demonstrates the effectiveness of a give-and-take attitude on the part of all concerned in bringing about greater coordination and development, both in quantity and quality, of services for the mentally retarded and their families.

opportunities to serve the retarded prompt a State crippled children's agency to develop its . . .

JOHN C. MacQUEEN, M.D.

SERVICES FOR CHILDREN WITH MULTIPLE HANDICAPS

The 1963 Federal legislation providing Federal financial support for services to the mentally retarded¹ offered a new opportunity and a new obligation to State crippled children's agencies. Accordingly, the Iowa State Services for Crippled Children has made changes in its existing programs and established new ones to provide better care for mentally retarded children, especially those with multiple handicaps. In describing these changes briefly in the following article, I have no intention of implying that Iowa's programs should be adopted by other crippled children's agencies, or that they are the best that can be designed. My purpose is to stimulate the interest of other crippled children's agencies to increase and improve their programs for multiply handicapped children in keeping with the needs of their State.

I am, of course, aware that the legal definition of the responsibilities of a crippled children's service varies from State to State. In some States the programs provide services only for children who have a

few specific diagnoses; in other States, they provide services for children with almost any kind of handicapping condition. While State crippled children's programs rarely provide complete services for retarded children who have no physical handicaps, few State programs exclude the retarded child if he has a physical handicap. Therefore, most State crippled children's agencies have a basis for increasing their services for the retarded and the multiple handicapped child by using the Federal funds earmarked for the mentally retarded.

When we began to consider how we could do this in Iowa, we reviewed the needs of children in our State who are both physically and mentally handicapped. In doing so, it became apparent to us that the responsibility for meeting many of the needs of these children should remain with the local welfare, health, and school facilities—for example, the provision of such everyday necessities as educational experiences, training for self-care, and the development of vocational skills. These services can appropri-

ately be provided through such facilities as local preschool day-care units, special education classes for the multiply handicapped in school systems, and sheltered workshops for handicapped adolescents.

Our review indicated that communities in Iowa were slowly accepting their responsibility to provide such services. The direct provision of these services by the State crippled children's agency seemed neither appropriate nor feasible. What the communities needed was consultation and encouragement from specially trained persons who could help them develop programs that would provide high-quality care to each child. Most communities have neither the resources to hire persons highly skilled in diagnosis or in supervising high-quality programs for the care of the multiply handicapped retarded person nor a caseload sufficiently varied to attract them. Our crippled children's agency, like other crippled children's agencies, includes on its staff persons with these special skills who could appropriately serve the communities as consultants.

Therefore, we decided to expand the State crippled children's program to provide the needed consultative services and thus interlock the agency's efforts with community programs for multiply handicapped retarded children.

In further reviewing the State program for handicapped children, we found that some of the services for the multiply handicapped offered by the crippled children's agency could be immediately expanded; some new services could be easily activated; and some new services, broad in scope, would require long-term planning and development. Most of the expanded services could be carried out by the agency's staff. The new services would require recruiting of new or additional staff. The activities and services requiring long-range planning would, for the greater part, involve complicated cooperative effort with other State agencies.

Mobile clinics

Our mobile field clinic was one service we could immediately expand. This diagnostic field clinic, which conducts 45 to 50 clinics a year throughout the State, has a long history of providing a high-quality, multiple-disciplinary clinical service. Before additional Federal funds became available, it was not possible to provide as many services as we

wished for the retarded, physically handicapped child. With the additional funds, it became possible to enlarge our staff, particularly our staff of clinical psychologists and speech and hearing specialists, and to provide the needed diagnostic services for the retarded, physically handicapped child.

For several years, we had been trying different methods in the clinic of serving children having emotional problems or problems related to retardation. We came to believe that such children would profit by a special sequence of examinations. Therefore, we instituted and continue to use the following procedure.

After the child's parents are interviewed by a social worker for the purpose of taking the child's history and identifying the problem, the child is examined by a pediatrician, a clinical psychologist, and other specialists as needed. At the conclusion of this sequence of examinations, the child and his parent return to the social worker for the discharge interview. The results of the examinations are available to the social worker, who may counsel the parent and, in particular, assist in designing a program of followup care.

Recently, we conducted a followup study of the children handled in this fashion during the field clinic examinations. We found that, on the whole, the parents responded positively to the experience and had, in a high proportion of instances, followed through with the suggested program of care. This confirmed our confidence in this examination procedure. Therefore, we have adapted it for use with the multiply handicapped retarded child, and believe it to be extremely effective.

After each field clinic, the regular clinic staff—pediatrician, a social worker, a public health nurse, a clinical psychologist, a speech and hearing consultant, a physical therapist—holds a community planning conference with representatives of the local school system, the welfare department, and the department of health. The staff reviews the records of selected patients examined in the clinic, discusses the clinic findings and recommendations, and helps the local people to plan an appropriate followup program.

Experience has proved these conferences to be extremely important. We are convinced that the recommendations must be carried out by local people and must be in keeping with available facilities.

suggest that a child attend a special day school if such a school does not exist in the community is not only unrealistic but can disrupt other aspects of his program. A more realistic recommendation for him might be to enroll him in a twice-a-week physical therapy program that is available.

Iowa is largely a rural State. One of the major difficulties in achieving good followup care for crippled children is in making arrangements to provide the specific educational and treatment programs needed by the multiply handicapped child. We have found that it is more difficult to organize community services to provide for the complex needs of the multiply handicapped child than for almost any other type of patient in our program.

In an attempt to further services for this type of patient, the crippled children's agency and the State Department of Public Instruction have created a joint position of consultant for the multiply handicapped. With training in special education, psychology, and physical therapy, this consultant helps communities make arrangements to provide the appropriate programs for specific handicapped children, especially children with particularly difficult problems who live in communities where health and educational services are limited. In thus demonstrating what can be done with appropriate effort for a multiply handicapped child, the consultant encourages the community to more nearly meet its needs. Our experience has indicated that in most communities there are people who will go to great lengths to make necessary arrangements to carry out appropriately designed programs for a handicapped child if they are informed about his needs. When the people of a community begin to see the advantages of specialized education and therapy programs, they begin to demand that the necessary specialists be employed to provide them.

Work with institutions

As the State agency for the care of crippled children, we have also considered the needs of the retarded children who reside in the State's two hospital-schools for the retarded. [See page 49.]

To find out whether we could be of assistance, we visited one of these institutions. We realized that we could provide only token assistance in alleviating the problems which the institutions face. In our



Efforts are being made in many places to bring better services to multiply handicapped children, such as this one.

discussion with the institution's administrative staff, it was agreed that the crippled children's agency could help in two ways:

1. By organizing a consultant team from our staff to include a pediatric neurologist, a pediatric orthopedist, and a speech and hearing examiner to go to the State hospital-school at regular intervals to review selected patients.

This consultative service, which is now getting under way, is expected not only to help the individual patients involved but also to provide valuable training experience for the agency's staff and the institution's staff.

2. By conducting a study of the indications for orthopedic surgical procedures for patients with severe skeletal-muscular problems.

This study is being carried out through the joint efforts of the staff of the crippled children's agency and of the State institution. A service-research activity, it has as its first purpose to evaluate the efficacy of surgical procedures in altering the kind of care a retarded patient with severe orthopedic handicaps must have, rather than to rehabilitate individual patients. A program designed to treat surgically all the patients in the hospital for all possible orthopedic needs would be beyond the professional and financial

resources of the State crippled children's agency.

Under the study, the institution's patients are classified according to their functional disability and degree of retardation. Cases are matched, and alternate cases have surgical procedures performed by the orthopedic consultant. We hope that 5 years hence we will as a result have much better information than we have had about the indications for orthopedic surgery in retarded children who have severe physical disability.

Other programs

Various members of the staff of the Iowa State Services for Crippled Children have designed and instituted new programs to increase the agency's services for the mentally retarded.

For example, one of our consulting pediatricians, who has a special interest in the newborn, in cooperation with a consulting obstetrician of the University of Iowa Hospital, has established a program to consider the problems of high-risk mothers and infants. In this program, mothers and infants with obstetrical and neonatal problems known to be related to physical handicapping and mental retardation are selected for study. Their problems are carefully documented in the medical center and a program of followup care, involving the staff nurses of the crippled children's agency, is maintained. Special clinics are conducted in various parts of the State for continued evaluation of these infants.

This study program illustrates an important change in our approach to medical care for infants. Before it was begun, we would have waited for the child to be referred to our service by his local physician when, and if, a handicap was noted. The results of the study may well have important implications

for the design of future programs of care for high risk infants and mothers.

Another of our pediatric consultants established a program, in cooperation with the mental retardation diagnostic clinic supported by the Division of Maternal and Child Health of the Iowa State Department of Health, to provide services for children with phenylketonuria. This program includes case finding, studies of the families of children known to have phenylketonuria, the provision of hospital care, the purchase of the essential dietary supplement, and the provision of followup home care. The program is demonstrating the advantages of providing carefully supervised care for children with this condition and of having a special clinic where the children can be evaluated and the parents can come to discuss their problems with professional persons and with other parents of children with phenylketonuria.

The director of our speech and hearing division who is particularly informed about the development of speech in mentally retarded children, has designed a program to evaluate the effectiveness of speech therapy provided for retarded children in special education classrooms. This program combines special service function with a clinical research activity. Supported by a special grant from the Federal Children's Bureau, it is part of a training program for professional persons in the field of speech and audiology who are or will be working with mentally retarded children.

Long-range planning

When we considered what the crippled children agency might do for the multiply handicapped, we recognized that our achievements would be limited if we concerned ourselves only with services that we could provide by unilateral activity. Programs are needed in our State that require long-range interagency planning. For example, the number and quality of preschool day-care facilities for multiply handicapped children leave much to be desired. Such facilities as we do have are for the most part poorly financed, inadequately staffed, have little medical supervision, and rarely provide the kind of comprehensive training needed by multiply handicapped children. A major problem is that no section of society or government has been clearly assigned the responsibility for the creation, support, and profes-

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sional supervision of facilities of this type.

There are a few facilities within the State that provide services and care for the multiply handicapped school-age child. These are most commonly a part of an enlightened school system.

Several years ago it became accepted practice in Iowa for moderately handicapped children to be retained in their homes and community rather than in a State residential school. Because many of these children are now adolescents, we are now confronted with the inadequacy of our community services for the multiply handicapped adolescent. The moderately handicapped adolescent has usually completed any special education program the community offers. He has no place to go. He cannot happily remain inactive in his home. He needs sheltered workshops and related facilities, but these are lacking in most communities.

In our State, those of us who have been planning services for the retarded have been impressed with the possibilities of rural counties combining their efforts to provide special services and facilities for disadvantaged persons. Specifically, we are proposing that regional units be created to serve a 6-to-8-county area with a population of approximately 150,000 people. Each regional unit would offer, among other services, special services for multiply handicapped children and adults, including day-care facilities, rehabilitation services, and sheltered workshops.

These combined county units will no doubt take several years to develop. As they do develop, the growing activities of the State Services for Crippled Children will enhance their effectiveness. Specifically, we propose to provide a traveling diagnostic-consultative clinic for the multiply handicapped children in the units. We would be greatly concerned about the development of such units if a multi-disciplinary consultative service were not responsible for the patient care.

As our agency became involved in long-range planning, we found that information about the prevalence and needs of multiply handicapped children in Iowa did not exist. Therefore, in conjunction with the Special Education Division of the Iowa State Department of Public Instruction, we carried out a case finding program in a six-county area, and followed this up with a series of special clinics for extensive examination of the children. Our experience

in this project will be helpful in preparing specific recommendations concerning the development of regional units.

In addition to the pragmatic information we obtained about the incidence of specific handicapping conditions, we made two important findings about the needs of adolescents and young adults:

1. Many multiply handicapped adolescents, retarded and nonretarded, are living at home, without hope and without opportunities for education or vocational training. Some of these patients are not severely handicapped but simply have no place to go, no one to relate to, and so no purpose in their lives. Their parents, who were diligent and enthusiastic in seeking appropriate attention for them when they were small children, have gradually accepted defeat and no longer seek opportunities for them.

2. Some young adults have physical handicaps which could be alleviated by physical therapy or surgery. For example, a hemiparetic person could develop some vocational skills if he were to receive reconstructive surgery of the involved wrist and hand. In some instances, the indicated surgical procedures could not be carried out at an earlier time because the child was still growing. The patient became disinterested in followup examinations that were not helpful and failed to remain under medical surveillance.

Whence the support?

A reader may, understandably, ask: "Where are the funds to support such an expansion of services for multiply handicapped retarded children?" The answer is clear. Federal funds are available for State crippled children's services, especially for those services which expand or improve services for the retarded. In the past, the major factor limiting the expansion of services for multiply handicapped retarded children was the amount of money available. Today the major factor that will determine how far such services will be expanded is the degree of enthusiasm and the ingenuity of the staff of State crippled children's services.

¹ Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January-February 1964.

THE GENETIC BASIS OF SOME ABNORMALITIES IN CHILDREN

ELLEN S. KANG, M.D.

With increasing frequency, reports of biological research are appearing which indicate that abnormalities of chromosomes are the basis of many disorders and anomalies in children. The story behind this is a chronicle of ingenious application to human material of new techniques developed in the field of cytogenetics, which resulted in increasing demonstrations that abnormalities in numbers or structure of chromosomes are associated with some human diseases and anomalies.

Chromosomes are rod-like, darkly staining bodies in the nucleus of cells which are normally constant in number in each species and which contain the hereditary factors or genes. Before defining abnormality in numbers of chromosomes, it was necessary to establish the normal number of chromosomes in man. Tjio and Levan in 1956,¹ found that normal human somatic cells contain 46 instead of 48 chromosomes, as was previously thought to be the normal complement. This was quickly verified by others.

Differences in terminology and in systems of numbering chromosomes led to a conference of researchers held in Denver, Colo., in 1960, where a numbering system was agreed upon. This was based upon the arrangement of prepared, photographed, and enlarged pairs of chromosomes in decreasing size. Such a photographed arrangement of chromosomes is called a karyogram or karyotype. The chromosomes can be studied by characterizing the location of the centromere (a characteristic constriction in the chromosome), the overall length of the chromosomes, and the length of the arms on either side of the centromere. The ratio between the lengths of the two arms separated by the centromere is constant for any one chromosome pair.

It is possible with present technical means to detect abnormalities of numbers of chromosomes as well

as some relatively massive structural abnormalities in individual chromosomes. The loss of nearly a half an arm from a small chromosome may be recognized, but a loss of a similar amount of genetic material from a larger chromosome may pass unnoticed. This amounts to a tremendous number of genes lost. The average chromosome is considered to have approximately 100,000 loci, the specific sites of gene location on a chromosome.

Normal cell division

In order to understand how abnormalities in the number of chromosomes might occur, it is well to recall the usual process of cell division. In simple cell division or mitosis, the distribution of chromosomes to daughter cells is precise with each cell receiving a full set of 46 chromosomes called a diploid set. Each chromosome doubles, completing the duplication from 46 to 92 chromosomes. The paired chromosomes separate and move to opposite daughter cells thus insuring the transfer of a full set of 46 chromosomes to each daughter cell.

In the development of the ovum and sperm, a reduction of the chromosome number of 46 by half to 23 chromosomes (known as a haploid) occurs in a process called meiosis. These haploids arise from specialized cells in the male and female organs. In meiosis two cell divisions are involved. In the first the chromosomes group into 23 pairs before separating into two daughter cells in a process called disjunction. Each daughter cell has a haploid number of chromosomes—23. Before the second meiotic division, the chromosomes in these haploids duplicate so that there are 46 in each. Then another process of disjunction occurs, producing daughter cells with 23 chromosomes. Thus, one diploid precursor cell gives



the chromosome karyotype of a male afflicted with Mongolism. Note the extra chromosome between position 21 and 2, where there are normally only two chromosomes in each position. The X and Y chromosomes in the lower right corner are the sex chromosomes.

ise to four haploid products. From the mechanical point of view, the basic difference between meiosis and mitosis is that in meiosis two cell divisions occur with only one chromosomal duplication, while in mitosis each cell division is accompanied by chromosomal duplication.

The new individual human being begins as a diploid cell formed from two haploid cells, each donated by a parent. From this one cell the individual develops by repeated cell multiplications, the chromosomal complement of each cell remaining constant by the process of mitosis.

The wrong numbers

Failure of disjunction in meiosis can result in an abnormality in the total chromosome number. Lejeune et al in 1959,² made a historic report of the discovery of 47 instead of 46 chromosomes in patients with Mongolism. These patients were shown to have cells with an extra chromosome, or trisomy, at position 21. This extra chromosome was thought most likely to be contributed by the maternal ovum. This is suggested by the higher incidence of Mongolism found among children born of older mothers but no correlation was found between Mongolism and paternal age.

It is believed that a woman's sex cells are already present before her birth. The aging of these cells may result in damage predisposing to a failure of

disjunction (nondisjunction). Both parents of Mongoloid children usually have a normal chromosomal complement in their somatic cells suggesting that the newly acquired extra chromosome occurred as a result of meiotic nondisjunction during gametogenesis, the development of the male and female sex cells.

Study of more cases of Mongolism resulted in reports of the presence of the normal complement of 46 chromosomes in somatic cells of some clinically typical cases.³ However, the structure of these chromosomes was abnormal, with an extra chromosome in one group and a deficiency in another group. Such abnormalities are called translocations. The defect produces the same effect as an extra chromosome 21 and is inherited from carriers of translocations who are apparently normal, presumably because loss of chromosome material in them is relatively little.

Parents of children who are translocation cases are likely to be young. Clinical interest in finding carriers of translocation lies in the possibility of being precise in advising parents of a Mongoloid child of the risk for recurrence in subsequent pregnancies. There is suggestive evidence that mothers who are translocation carriers increase the risk of nondisjunction.

In Mongolism, nondisjunction may not be confined to the sex cell line. Several children have been found who have features of Mongolism and whose cells show several different karyotypes. This is called mosaicism and is thought to result from abnormal cell division during embryonic development.

Two other significant trisomic states have been reported—13-15 trisomy and 17-18 trisomy—in autosomes, the ordinary paired chromosomes as distinguished from sex chromosomes. In both these conditions, parents have apparently normal karyotypes. Both conditions cause early death. Single examples of several other autosomal trisomic conditions have been claimed. The most remarkable autosomal abnormality yet reported was a case with 69 chromosomes in a male with multiple congenital abnormalities.

The sex chromosomes

Investigation of cases of disturbed physical sex development has revealed many types of abnormality of the sex chromosomes. Chromosomal abnormality was originally suspected in such cases from examination of scrapings of the inside of the cheeks for the presence of a darkly staining intranuclear chromatin

body, normally found in females but not in males.

The normal male sex chromosomal pattern is XY and the normal female pattern XX. Abnormalities of the sex chromosomes have been demonstrated in four conditions: Klinefelter's syndrome, Turner's syndrome, the triplo-X female, and in some hermaphroditism and pseudohermaphroditism. Patients with Klinefelter's syndrome have a general male appearance with male external sex organs but are sterile, frequently mentally retarded, and have nuclear chromatin bodies characteristic of females. The sex chromosomal pattern of XXY is found in the majority of individuals with this syndrome.

Turner's syndrome usually occurs in persons who appear to be females but who are sterile, fail to show breast development, are retarded in growth, and have webbing of the neck. Most of them also have a congenital heart defect and are mentally retarded. In most cases, the sex-chromatin pattern is negative and the karyotype analysis reveals 45 chromosomes, only one sex chromosome being present. However, sex-chromatin positive cases of Turner's syndrome have been reported.

Several cases of females with an XXX pattern have been reported. Such women are usually fertile and their offspring normal.

Abnormalities of sex chromosomal patterns have also been found in a few patients with a confusion of sexual organs.

Chromosomal structure

The first clinical condition associated with a deletion of a portion of a chromosome was cat-cry syndrome (*cri du chat*) described by Lejeune.⁴ This condition is characterized by a catlike cry and mental and physical retardation. It is associated with a deletion of the short-arm of chromosome number 5, and is definitely compatible with life. Heretofore, the deletion of a significant portion of an autosome, in contrast to such a deletion in a sex chromosome, was generally believed to be lethal. In one case of *cri du chat* reported by Lejeune, a phenotypically normal mother was found to have a balanced translocation between one of the 4-5 group of chromosomes and one of the

13-15 group. The carrier condition in a parent definitely increases the risk of future occurrence.

The question of chromosomal abnormality in spontaneous abortions and stillbirths has recently been pursued.⁵ Highly significant incidences of chromosomal abnormalities have been reported. The relatively few types of such abnormalities noted in these studies are interpreted as being due to the more lethal nature of other chromosomal abnormalities, resulting in loss of the conceptus well before pregnancy is clinically established.

Well before technical advances permitted the identification of structural or numerical abnormalities of chromosomes, there was much evidence for the implication of these hereditary units in the causation of human disease and anomalies. Based on Mendel's investigations of inherited characteristics of peas, a system of genetic principles was developed which was extended by Garrod to disease in man,⁶ thus laying the foundation for the study of heredity and inborn errors of metabolism.

Presumably, hereditary disorders of metabolism such as phenylketonuria and galactosemia, involve a specific locus on a chromosome, or, more precisely, a molecular sequence on a locus and are not only undetectable by present-day cytologic techniques but may never be detectable by this approach. These disorders are better detected by biochemical techniques. Rapid advances in the recognition of these different types of expression of hereditary disorders have broadened the scope of genetics tremendously.

The basic value of the rapidly accumulated knowledge in cytogenetics rests in its immediate application in the practice of medicine, as in counseling parents on the etiology and irreversibility of the condition and the risk of recurrence in future pregnancies and possible rehabilitation of the patient.

¹ Tjio, J. H.; Levan, A.: The chromosome number of man. *Hereditas*, 42: 1-2, 1956.

² Lejeune, J.; Gautier, M.; Turpin, R.: Les chromosomes somatiques de neuf enfants mongoliens. *Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences, Paris*, 248: 1721-1722, Mar. 16, 1959.

³ Polani, P. E.; Briggs, J. H.; Ford, C. E.; Clarke, C. M.; Berg, J. M.: A mongol girl with 46 chromosomes. *Lancet*, 1: 721-724, Apr. 2, 1960.

⁴ Lejeune, J. et al.: Trois cas de délétion partielle du bras court d'un chromosome 5. *Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences, Paris*, 257: 3098-3102, November 1963.

⁵ Carr, D. H.: Chromosome studies in abortuses and stillborn infants. *Lancet*, 2: 603-606, Sept. 21, 1963.

⁶ Garrod, A. E.: The Croonian lectures on inborn errors of metabolism. *Lancet*, 2: 1-7, July 4, 1908; 7379, July 11, 1908; 142-148, July 11, 1908; 214-220, July 25, 1908.

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TRAINING NONPROFESSIONALS for A CHILD WELFARE SERVICE

LELA B. COSTIN

One of the most crucial problems in all the service fields today—including public child welfare—is the widening gap between available professional manpower and service needs. This has resulted in a growing realization that efforts to improve the quality of services cannot await the unforeseeable future when there will be enough professional social workers to fill all social work positions. The project to be reported here is one response to that realization. On the theory that schools of social work are in a favorable position to help agencies develop the potentials for useful service of “non-professionals” (persons without a graduate degree in social work), the Jane Addams Graduate School of Social Work, University of Illinois, in 1962 undertook a 3-year cooperative training program with 10 State public child welfare agencies. The project was focused on the agencies’ responsibility for licensing family homes for child care.

Financed in part with a Federal grant from the Children’s Bureau, the project was based on two assumptions: (1) That an imperative first step in improving service today is a systematic analysis of the tasks in child welfare to determine those which the nonprofessional person can do effectively; and (2) that the licensing function can be used to raise the quality of care for large numbers of children. Since the plan and rationale of the study have been reported earlier,¹ this article will focus on the results.

The project had one central purpose: to demonstrate that the nonprofessional staff person can adequately perform the tasks involved in the licensing of family homes for the day care of children. Within this central purpose were six specific aims: (1) to identify the tasks in licensing family homes and the knowledge and skills needed to perform them; (2) to ascertain the relative importance of these tasks; (3) to develop a curriculum and set of teaching materials for a course to teach the licensing process; (4) to establish a level of competence against which a licensing worker’s performance can be measured; (5) to demonstrate and evaluate three different ways of training nonprofessional persons for the licensing

The directors of the project reported here were Lela B. Costin and Jennette R. Gruener. Ellen Handler was research associate and Mildred S. Johnson, supervisor of training. The participating States were Illinois, Indiana, Iowa, Minnesota, Missouri, Nebraska, New York, Ohio, Pennsylvania, and Texas.

tasks in order to identify some of the essential ingredients of an inservice training course for licensing workers; and (6) to determine, through evaluation of trainees' on-the-job performance, those tasks which the nonprofessional persons in the project performed successfully, those tasks which presented difficulty, and some factors in the difficulty.

Task analysis

A great deal of activity preceded the actual demonstrations. The first major step was an *analysis of the content of the licensing function*. The project staff and representatives of a public child welfare agency began by tentatively enumerating the tasks involved in licensing family homes. On the basis of this tentative analysis, areas of knowledge and specific skills that would be needed by the trainees were identified. The material developed provided the foundation for the draft of a teaching syllabus.

The next step was to spell out the tasks more clearly and to rate their importance according to the opinions of experienced social workers. Two panels of social workers were asked to indicate the relative importance of the tasks listed in fulfilling the agency responsibility for licensing family homes. Their responses were used in revising the syllabus, in constructing tests to measure a trainee's performance of the specific tasks, and in developing an overall standard for competence.

The first panel was composed of 92 social workers in 26 States having laws requiring the licensing of family homes and group facilities for the day care of children. All the panel members were designated by the supervisory staff of the licensing units in these States as staff members who could appropriately rate the importance of licensing tasks. The second panel was composed of 21 experts in 16 States, known to be especially interested, knowledgeable, or experienced in the licensing of family homes, who were engaged in work involving problems of licensing practice and the relationship of these problems to the use of scarce social work manpower. They included State child welfare administrators, staff development directors, day-care consultants, and State or regional supervisors of child welfare or licensing services.

The opinions of the two panels of social workers, in essential agreement, considerably extended the original analysis of the licensing function. Briefly, they said that the tasks which were most important in licensing family homes were those requiring skills in applying tangible standards to directly observable

situations. They also agreed that the most important tasks were those which involved dealing with "primary" persons—applicants for a license, colleagues in the agency, or other persons who play a direct role in determining eligibility for a child-care license.

In contrast, tasks which received generally lower ratings were those requiring skills in applying more intangible standards, such as dealing with problems arising out of psychological situations. Other tasks rated as relatively low in importance were tasks involved in dealing with "secondary" persons—spouses and children of applicants, others in their household such as boarders and relatives, the applicants' references and friends, or the parents of children in family day care.

Further examination of the panels' opinions showed that the tasks with high ratings were most usually ones which would be carried out during the early steps in the licensing process—the application the home study, or the formulation of a recommendation for issuance or nonissuance of a license. Those tasks which received low ratings were more often those which would be carried out while providing supervision-consultation to the licensee (a process in which the provision of consultation to the licensee is combined with the supervision of the home for its compliance with established standards), performing the community organization aspects of a licensing program, or offering service to the parents of children placed by their parents in family day-care homes without the intermediate service of a social agency—usually called "independent placements."

This difference between the nature of tasks receiving high and low ratings was consistent with a pattern of agency practice that the project staff had already observed. Tasks given high ratings of importance by the panels seemed to be those which are carried out most frequently, and which are most often included in a licensing program even when the agency cannot fully carry out its licensing responsibility. The tasks receiving low ratings were those which are

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least often found in licensing programs, are not so well understood, and are most often dispensed with when pressures for other services are great and staff is in short supply.

For the purposes of the project, the tasks with the higher ratings were called the "central" tasks for meeting an agency's licensing responsibility on an acceptable though minimal basis. Tasks with lower ratings were called "peripheral" tasks for meeting the agency's minimal responsibility.

Other preliminary activities

The second major activity preceding the training demonstrations was the *preparation of a curriculum² and a set of teaching materials¹* on which to base the instruction in the project. [See page 83.]

A third preliminary activity was the *establishment of a standard of competence* against which a trainee's performance on the job could be measured. This was done by considering the tasks essential in a licensing program—those which must be carried out if the public agency is to meet its responsibility, even minimally. The basic criterion identified by the project staff for determining a worker's level of competence was his performance in meeting the agency's minimal responsibility to the persons directly served by the licensing function and to the supporting public. As a result, a worker's previous training and experience were not considered criteria of competence. Instead, judgment of competence was based directly on the minimal requirements of the task under consideration and the degree to which the worker's performance of the task met these requirements. Performance below that level was labeled as unsatisfactory, regardless of the worker's previous training or experience.

Responses of the panel of experts underwent a factor analysis to set the competence level on two of our evaluation measures: a supervisory rating scale or use by the agency supervisors and a record rating scale. Project staff consensus, with the experts' body of opinion as a guide, was used to set the competence level for tape recorded initial interviews, additional case record material, and results of a written test of trainee's judgments of situations presented in case vignettes.

A fourth predemonstration activity was a *pilot training program* conducted by project staff on the school's premises for six trainees from the Illinois Department of Children and Family Services. The purpose of this early training program was to test the usefulness of cooperation between a school of

social work and a State child welfare agency in training nonprofessional staff members and to test the feasibility of further investigation into the licensing function and ways of training nonprofessional persons for the tasks it requires.

The demonstrations

The project included three demonstrations, using different training procedures, involving a total of 41 licensing workers who had no professional social work education. Demonstration I included eight trainees from four States who took part in a training course conducted by the school of social work. Demonstration II involved two State welfare departments, each of which conducted an inservice training program for their own licensing employees, one for 10 trainees and one for 3 trainees. Demonstration III consisted of a course given by the school of social work for 16 child welfare supervisors from nine States, each of whom afterward trained one or more nonprofessional licensing worker. Altogether 20 workers were trained in Demonstration III.

The various groups of nonprofessional trainees were similar with respect to age, levels of education, social work experience, verbal reasoning ability (as measured by the Cooperative School and College Ability Test, Part I),³ and attitudes toward family life (as measured by the Parental Attitude Research Instrument).^{4, 5} We have no data to indicate whether these trainees were representative of the nonprofessional persons generally available to public welfare agencies. However, from our knowledge of the hiring procedures and recruiting methods used by the States which participated in the project, we assume that they were.

As an early assessment of the success of the training courses, we sought to answer the questions: "How much did the trainee learn from the course? Did he have significantly more knowledge of the content of the materials used when the course ended than when it began?"

An objective test was given to the trainees at the beginning and end of the formal training in each of the demonstrations. All but one had a higher score after completion of the course. The difference between the mean scores of the precourse and postcourse test was statistically significant for each group.

The various measures used for evaluation were aimed at the core of the investigation—determining the extent to which the nonprofessional trainee met at least minimum standards of competence in the per-

formance of the central and peripheral tasks in the licensing of family homes.

The employing agencies were clearly satisfied with the performance of the trainees during the 6-month period of work following training. Supervisors rated most of the trainees well above the level of competence which would meet minimum agency responsibility on all the tasks of licensing, both central and peripheral.

Growth of competence

Except for recording, the project's additional evaluative instruments similarly indicated that the trainees possessed at least minimum competence. They showed that most of the trainees could do most of the tasks involved in licensing family homes and especially those basic to the licensing process—receiving and handling applications, studying the home, and drawing together facts and opinions on which to base a judgment about whether or not to issue a license.

None of the trainees performed recording tasks at the level of competence set by the panel of experts as necessary to meet minimum agency responsibility, although the case records evaluated in the project had been accepted by the trainees' supervisors as satisfactory. The experts apparently set a theoretical standard for record writing different from the expectations in agency practice, thus illustrating a current confusion about the purpose and nature of social work recording. Other probable explanations for the trainees' failure to develop greater competency in this area are: (1) recording skills are difficult to acquire; (2) special attention was not given to recording either in the project's training sessions or in its consultation with the agencies about on-the-job training; (3) the traditional recording procedures of the agencies provided a sterile model for trainees.

About half the trainees apparently performed tasks successfully which in practice are not usually accorded a place of central importance in the licensing of family day-care homes and which are generally thought to be most difficult—aspects of community organization and the provision of supervision-consultation to the licensee.

An examination of the ways in which the trainees carried out community organization tasks showed that nonprofessional workers can be helped to develop a sense of community responsibility, to see the interrelationship of child welfare problems in general to their own day-by-day job, to furnish ideas to the agency, and to carry out community organization

tasks effectively with the backing of their supervisor and administrators.

The community organization tasks carried out by trainees included:

- Interpretation of the licensing function (a) to colleagues—in informal discussions, in formal presentations at staff meetings, and, in one instance at a State meeting for new child welfare workers (b) to representatives of other governmental agencies such as municipal zoning commissions, with emphasis upon the agencies' common interests and goals; (c) to staff and board members of voluntary family and child-placing agencies, with emphasis upon the protective element in licensing; and (d) to community clubs, civic groups, and high school classes through speeches.

- Work with newspapers to publicize the need for licensing day-care homes and to discourage advertising of unlicensed family day-care homes.

- Participation in radio and television interviews or formal presentations about licensing.

- Participation on community committees set up to deal with various problems related to child welfare functions.

- Participation in formal community surveys of day-care resources.

- Preparation and distribution of information pamphlets dealing with day care and licensing.

Trainees generally were supported in such community efforts by their agency administrators and supervisors. However, most of these activities came about through the demonstration, rather than as an integral part of an already organized, assertive agency program of community education.

While the question of whether nonprofessional persons can successfully perform the tasks of supervising and consulting with the licensee (supervision consultation) cannot be answered from our data without some qualification, the scores on the supervisory rating scale indicated that when the trainees carried out such tasks, their performance generally satisfied their agency supervisors. Furthermore, other evaluative measures showed that many trainees successfully performed such tasks in various kinds of case situations, thus reinforcing our conclusion that nonprofessional persons can be taught to perform the tasks of supervision-consultation effectively. Much seemed to depend upon the expectations of the

agency and the trainee's supervisor. Trainees who did not perform such tasks even when the case situation seemed to warrant them usually had had little support from their agency to do so.

It must be pointed out that the full potentialities of nonprofessional persons for carrying out the function of licensing family homes were not measured. Our evaluative procedures did not provide for such complete measurement nor was the agency work setting appropriate for it. There is reason to believe, however, that the potentialities of many of the trainees for performing the tasks under study were higher than the agencies required.

Tasks presenting difficulty

There were some tasks which some trainees did not perform successfully: those involving the use of authority when a home is found to be unsatisfactory; and those required for making an adequate study at a time of relicensing. The project is recommending that nonprofessional workers be given additional training or supervisory help with these tasks as well as with the provision of supervision-consultation to the licensee. The tasks which presented special difficulty to some trainees were: explaining the meaning and purpose of the licensing law to applicants and licensees; acting on their right as representatives of the State to "require" and "prohibit"; tempering an applicant's resistance to licensing; dealing with applicants whose homes are not licensable; insisting that substandard licensees conform with the State's standards; handling complaints; and rejecting a substandard home when relicensing is due.

The findings indicated that the nonprofessional worker's competence in such tasks depended largely on how clear his agency's expectations were about the use of authority and how much opportunity for support and learning the agency provided its entire staff, professional and nonprofessional, in this regard.

The following factors seemed to be related to the trainees' difficulties in carrying out an adequate study at time of relicensing:

- Heavy workloads which often left time for only brief reappraisal of the home instead of a thorough study and the provision of consultation to help the licensee bring the home up to standards.
- The failure of agencies to recognize the potentiality in the relicensing process for improving the quality of care for children.

- The unpleasantness encountered in denying a license renewal to a home once approved for child-care service but no longer meeting the agency's standards.

Tasks involved in working with parents of children in independent placement were performed so infrequently by trainees that their supervisors usually said they had no basis for judging their performance. In spite of the increasing number of parents who place their children independently in day care, there seems to be a general lack of agency activity in relation to them. Yet when trainees did have opportunity to work with such parents, their supervisors were usually satisfied with their performance. These findings suggest certain questions: What are the needs of such parents for service? What kind of service can and should be offered to them? Under what auspices should this service be given?

Group comparison

When a comparison was made of the trainees' performance on the job in each of the three training groups, only minor differences appeared. No group stood out as clearly superior to the others in achievement or performance. At first glance, this finding may seem to indicate that the choice of training methods is not important in preparing nonprofessional persons to perform the tasks in licensing family day-care homes. If this were so, then the agency might choose a training plan on the basis of cost, administrative setting, the teaching personnel available, or other practical reasons.

It must be pointed out, however, that these training demonstrations did not illustrate actual differences in *method*. The differences were in *auspices* and *teaching personnel*. Overriding them were important constant factors: the same set of teaching materials, based on an analysis of the function for which training was being given; the same teaching objectives, based on the same theories of teaching and learning; and the same careful pre-session planning.

The study does not warrant a conclusion that the means of training are unimportant. It does indicate that a variety of means may prove successful, given certain important ingredients, such as useful training materials, clear and consistent teaching objectives, thorough planning, and agency support of the functions for which the training is given. A logical sequel to this project would be to measure the performance of nonprofessionals trained by a program

of self-study, using the same set of training materials and evaluative measures as in this project.

As part of the project's evaluation, questionnaires were sent to trainees, supervisors, and State representatives serving the project in a liaison capacity. A large majority of the respondents rated the training course as very helpful. The most positive statements came from the supervisors' training demonstration—Demonstration III.

In general, the participants gave high ratings to the usefulness, organization, and coverage of the training materials. This would seem to confirm the assumption that training materials for nonprofessional workers can be developed outside the employing agency and can be adapted to the agency's specific procedures, level of practice, and the skills of its available teaching personnel.

The responses also indicated that, where agency conditions are conducive to continued teaching and learning on the job, a training program can strengthen the role of the agency's supervisors and the satisfactions of the supervisor-worker relationship.

Some obstacles

Information from the agencies, as well as the participants, made it obvious that external pressures frequently prevented a trainee from fully using the knowledge he had acquired during the training sessions. One pressure came from the great demand in communities for family day-care homes, a demand which contributed to the incompleteness of home studies or a tendency to compromise with standards. The pressure felt within agencies to keep a home in use for particular children was often very great, particularly when alternative arrangements for the children's care were not visible.

Another obstacle to a trainee's making full use of his training often lay in the agency's hesitation to require conformity to its standards for family day care because of the danger of damaging its "image" in a community where a licensing service was just being initiated. This was particularly true in communities where there had been no program to educate the public about the licensing law.

Still another obstacle was presented by lack of administrative or supervisory backing for denying a license when a denial was indicated. The use of authority was obviously a problem among the professional as well as the nonprofessional staff members of many agencies.

And, in most agencies, heavy workloads always threatened to get in the way of an adequate consideration of all the matters relevant to a decision about issuing or not issuing a license.

School-agency relationships

What has been learned through this project about the feasibility of a cooperative staff development venture between a school of social work and public child welfare agencies?

Certainly, difficulties were encountered along the way. The potential obstacles to successful cooperation usually stemmed from the differences in function and organizational structure of school and agency. These created difficulties in communication, in recruiting States for participation in the project, and in reaching a common understanding of what to expect from the demonstrations. In most instances these difficulties were dealt with successfully, a fact largely attributable to the high degree of cooperation received from the participating public child welfare agencies.

In spite of its problems, this project has demonstrated that a school of social work and a group of public welfare agencies can move together toward common educational goals and toward effecting a closer relationship between social work education and practice. The school received many expressions of appreciation from agency staff members for the satisfactions realized in this cooperative venture. In turn, the representatives of the school who were on the project staff gained reinforcement for their already close identification with the public child welfare field, as well as new learning that can be used to enrich their teaching efforts in the graduate classroom.

The project clearly demonstrated the effectiveness of school-agency cooperation and the importance of continued communication between the two.

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SELECTING FOSTER PARENTS for DISTURBED CHILDREN

ANTHONY N. MALUCCIO

Today child welfare agencies the country over are finding that the children who are brought to them for foster family placement are on the whole in greater emotional difficulty than those of the past. This change has resulted in the need for more intensive evaluation of prospective foster parents and their ability to cope constructively with the difficulties presented by a disturbed child.¹⁻³ It has also resulted in an increasing concern about the effect of such a child's placement on the members of the foster family and on the family balance and integration. Child welfare workers are becoming aware that the placement of a traumatized child may awaken latent conflicts in the foster parents and lead to disruption of their own personal or family life.^{4, 5} What are some of the elements in the placement of a disturbed child which may upset individual or group adjustment within a foster family? And what

are their implications for foster parent selection? In exploring these questions, this paper will focus on foster parents for "emotionally disturbed children"—children showing severe distress, maladaptive behavior, or pathological character traits. But much of what it says may be applied, in varying degrees, to all foster parents.

Impact of placement

On the child. As a child is placed in a foster home, he is often faced with a crisis in his sense of identity and security which may result in a strong feeling of loss and helplessness. At the same time, being separated from his parents reactivates his unresolved conflicts in regard to them, conflicts which stem from his feelings of deprivation, rejection, or hostility. His reaction in the foster home, therefore, may include angry testing out, depression, emotional detachment, and withdrawal.⁶

Following placement, the child may behave in the same way he would in reacting to his own parents' needs and behavior patterns, instead of reacting

or the ideas presented here, the author is partly indebted to Leonard M. Lasser, M.D., formerly psychiatric consultant, and Alice Y. Moe, director of casework, Children's Village Programs, Children's Services of Connecticut.

realistically to what the new foster family is offering. Many foster children apparently try to recreate their own family situation in the foster home, probably as a desperate measure against their sense of lost identity and insecurity. As Littner has observed, the child's need to repeat his past constitutes "one of various defense mechanisms he uses for dealing with problems in the present."⁷

The foster family's early efforts to create a positive environment for the child often arouse in him further resentment toward his own parents. It is as if he suddenly becomes aware of everything he has needed in life and has not received through his own parents. The newly aroused anger adds to the strength of the child's longstanding resentment and leads to intensification of his guilt feelings, his sense of rejection, and his self-image as a worthless and unwanted child. All this may stimulate aggressive testing-out behavior, which results in increased anxiety in both the child and the foster parents.

On natural parents. A child's placement in foster care affects different natural parents differently, depending on such factors as their personality structure, the special meaning the child has for them, and the family situation at the time of placement. Some common themes occur, however, in the reactions of parents who continue to see their child after he has been placed. For example, the very fact of placement, in confirming the parents' inability to care for their child, reinforces their sense of inadequacy, failure, and loss. A consequent sense of isolation and an intensified sense of guilt over their hostile feelings toward the child arouse in them further anxiety.

An emotionally disturbed child typically relates to his parents on an infantile level, and he often reacts with rage when his demands for primitive gratification are not met.⁸ Following placement in

foster care, such a child continues to make demands on his own parents, and their inability to meet his needs intensifies their feelings of guilt and anger. Through their continuing contacts with the child, the parents communicate their anxiety and their conflicting attitudes toward him and the placement, thus contributing to the perpetuation of the child's ambivalent feelings toward them and toward himself. Some parents may inwardly need to sabotage the placement, particularly as they see the foster parents succeeding in building a positive relationship with the child, something they, the child's own parents had been unable to do.

On the foster family. Thus, a disturbed child brings into his foster placement intense inner turmoil and unresolved conflicts in such areas as aggression, ambivalence, and identification. Furthermore the child's anger against his own parents is often projected directly onto the foster parents, who are readily accessible as substitute parental figures. Because of the force and variety of the feelings which come into play in such a situation, the introduction of a disturbed foster child into a family can lead to the arousal of the foster parents' unresolved childhood conflicts. At the same time, the coming of a foster child may produce a rapid shift in the family's pattern of living, requiring a degree of strength and flexibility not all families possess. Moreover, the child's aggressive behavior may bring more stress to the foster parents and their children than they can bear.

Another source of anxiety for both foster parent and foster child is their relationship with the agency. The nature of the relationship is conducive to the kind of reaction in the foster parents known in psychiatry as "transference," with the foster parents unconsciously viewing the caseworker as their own parent and the agency as the ultimate parental authority.⁹ Moreover, since the emphasis of this relationship is on treatment of the child disturbance, considerable inward turmoil may have to be aroused in the foster child in order to have personal change and growth occur through the therapeutic process. This, in turn, may arouse turmoil within the foster parents.

Thus, as they take a disturbed child into their home, foster parents are faced with many elements of potential stress. A result often is the arousal of latent personal and family conflicts within the foster home as well as the reawakening of unresolved conflicts from the foster parents' earlier life with their

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own parents. When these conflicts are so severe as to disrupt the foster parents' emotional equilibrium or the foster family's ability to function, a crisis is created which is not always amenable to resolution, even with intensive and skilled casework service. The strain on both child and foster family may then require the child's removal from the home.

Selection of foster parents

A major purpose of a foster home study is to assess the degree of stress which the placement of a child might create in the prospective foster family and the family's capacity for handling this stress with agency help. However, in the current state of our knowledge, this is easier said than done. Nevertheless, there are certain factors which if observed and assessed can be helpful in the process of foster parent selection, though these factors may not by themselves be definitive indicators of the foster parents' capacity for providing the right kind of home for the child nor be applicable in every case.

The first factor needing clarification is the applicants' typical pattern of coping with anxiety, as reflected in their responses to normal as well as unusual crises in their own lives. Applicants can be expected to have difficulty in handling the stress created by a foster child, if their characteristic reaction to anxiety has been denial or withdrawal.

Another factor needing assessment is the foster parents' degree of sensitivity to the feelings and needs of others. If the foster parents have successfully resolved the conflicts in their own experiences, neurotic or otherwise, they may have a heightened awareness of the suffering and anxiety which human beings experience as part of their growth process. Having such an awareness is particularly important for anyone working with a disturbed child.

Prospective foster parents apply for a foster child out of multiple and complex needs of their own. Often they are searching for personal development and for help with the resolution of their conflicts.^{5, 10-12} If their coming to the agency seems chiefly a response to a deeply neurotic need—a search for a way of working out severe difficulties of their own—they probably could not be helpful to a foster child and could be overwhelmed by the child's neurotic problems.

In other words, if foster parents have not had a truly creative growth experience in childhood, they will probably not be able to encourage the child to separate himself from the constrictions inherent in

his relationship with his own parents. If they do not have the capacity for further growth themselves, they will not be able to tolerate a child's development beyond their own level. When a child is placed with such people, there may ensue an apparently untroubled situation in which the child simply stands still. But if the child strives to move beyond the foster parents' own level of development, a crisis may occur, perhaps leading to rejection and removal of the child from the foster home.

A third factor needing careful examination is the degree to which the prospective foster parents are likely to become emotionally involved with a foster child. Overidentification on the part of foster parents, even if it has a positive motivation, can prevent a child from freely developing his own personality. Foster parents should be able to maintain some emotional distance between themselves and the child. This does not mean that foster parents should not relate closely to a child; it does mean that they should not become so emotionally involved that their own personality becomes enmeshed in the child's character structure and problems. Ideally, the foster parents should be able to give a child what he needs in a way that respects his individuality and promotes his growth, instead of encouraging him to become an extension of themselves. In short, prospective foster parents must demonstrate that their psychological separation from their own parents is sufficiently strong to allow them to stimulate the foster child to develop as a separate person.

The following example illustrates the importance of the foster parents' capacity for growth within themselves and their ability to tolerate growth in the foster child.

Mr. and Mrs. A were a stable couple in their early fifties, who had had no children of their own. Both came from large families and had helped to rear several of their nephews and nieces and thus had achieved some satisfaction as substitute parents. They had always been afraid of close involvement with a child, however, and had never applied for adoption.

Their interest in becoming foster parents was stimulated by their having lost close contact with their many nieces and nephews because they had moved to another town. During the home study, Mr. and Mrs. A related comfortably with the agency's worker and showed their eagerness to give loving care to a child.

Judy, the child placed with them, was an immature and disorganized adolescent who had been diagnosed as a borderline schizophrenic. Since babyhood she had lived with a series of foster parents, none of whom could tolerate her immature and bizarre behavior.

Before being placed with the A's, Judy had entered into psychiatric treatment. Following placement, treatment

progressed steadily, as Judy began to pour out her feelings and to move into direct self-exploration. At the same time, she made marked demands on the A's, through angry testing out, open belligerence, and with Mr. A, the type of seductive behavior characteristic of early adolescence. She seemed to be suddenly and urgently struggling to grow.

The A's were upset by Judy's demands, but they expressed their anxiety about these new experiences to the caseworker and thus reached out for the agency's help. This helped them to avoid responding in a personal way to Judy's testing out and to allow her to express her feelings.

As a result of her therapy as well as her positive experience with the A's, Judy, in less than a year, made significant strides toward emotional security, which were reflected in improved social and academic functioning. Simultaneously, while going through a distressing experience, the A's effected changes within themselves—as evidenced by increased self-awareness, better self-image, and sense of fulfillment as parents.

Thus, the outcome of a placement can depend on the foster parents' capacity for being stimulated by anxiety to further personal growth as well as on their readiness to encourage the child's own efforts to grow. A decisive factor can be the foster parents' ability to use casework services.

A further factor to be assessed in evaluating a potential foster home is the degree of the applicants' inner security. They should possess enough security to allow the agency's worker to get to know them intimately, with all their liabilities and assets; to determine whether their needs, both healthy and neurotic, will best be met by caring for a foster child and, if so, what kind of a foster child; and to judge their capacity for reaching out for appropriate help when needed.

Assessment of family strength

In addition to an evaluation of the prospective foster parents' personality structure, the home study should include an assessment of family strengths and dynamics.¹³ An assumption that, since the foster parents' own children have grown up successfully, the foster child will do likewise in the same home can be erroneous. In a normal family, the family dynamics are oriented toward child and parents accommodating themselves to each other's needs over a long period of time; the foster child, in contrast, has not had this opportunity. As Kline and Overstreet have pointed out, "in the majority of cases . . . he has learned disturbed and disturbing ways of relating to the world around him to maintain his psychological equilibrium."⁹

Because the introduction of a foster child may

seriously affect family relationships, it is important to determine whether the family structure is healthy enough to withstand the additional pressures of a disturbed child. If there is considerable actual or potential family pathology, the foster child may become the focus of hostility and anxiety.

Sometimes, for example, the foster parents' latent anxiety about their own child emerges when they receive a foster child, and so much anxiety is engendered that the foster parents finally request removal of the foster child. The marital relationship of the foster parents must contain sufficient gratification so that neither partner is threatened by the foster child and neither uses the child to fill needs which more properly should be filled by the other. Thus an assessment should be made of the quality of the applicants' marital relationship and the implications of their request for a foster child.

Mr. and Mrs. B were in their late twenties when they applied to become foster parents. They wanted children of their own and had been married several years, but Mrs. B had been unable to conceive.

Mr. B was the oldest of several children of an alcoholic father and an emotionally distant mother. A successful businessman with a quiet, reserved manner, he, nevertheless, revealed some indications of a warm and secure personality.

Mrs. B was the youngest child of parents who had given her much materially but little emotionally. An outgoing, demonstrative woman, she returned her husband's respect. However she showed some signs of receiving insufficient emotional gratification from the marriage.

George, the foster child placed with the B's, was a disorganized and infantile 9-year-old. During his first 2 years with the B's, Mrs. B met his infantile needs so effectively that George slowly began to grow emotionally. As she became more involved with George, Mrs. B became less attentive to her husband. Her own needs were to a large extent met through the boy, who developed into a responsive and rewarding youngster.

The B's invested a great deal of effort in helping George and in working with the agency. But as he grew into adolescence, the boy's needs changed and the foster parents found it harder to work with him. The resulting strain had a deteriorating effect on the couple's marital relationship. Mrs. B complained to her husband that George was a demanding child requiring all her time; she told George that her husband was an inadequate, selfish man. Mr. B withdrew further from his wife, and her sense of dissatisfaction and feeling of being rejected by him were thereby intensified. George began to regress.

When the first signs of deterioration in the B's marital relationship appeared, the agency offered to provide them with marital counseling, either directly or through other resources; but each maintained that there would be no difficulty if the other changed. In casework sessions, the B's were unable to look at what was happening in their relationship. Mrs. B blamed her husband for not being interested in her, while he

complained that she was greatly exaggerating the situation. When, after several months, the B's were still unable to effect any changes in their relationship, the agency decided to remove George from their home. There was no doubt about George's having progressed through living in the B's home. However, in view of his stage of development and the B's marital tension, the agency concluded that his continued placement with them would not be beneficial to either George or the B's.

Following his placement in the home of a more mature and stable couple, George showed surprising ability to work through some of his adolescent struggles and to form more positive relationships with both his foster father and foster mother.

In the foregoing example, the foster parents' latent marital difficulties apparently were activated and reinforced through the introduction of a child from whom the foster mother could gain gratification while driving her husband further away from her. A more thorough evaluation of the foster parents' marital relationship, with all its subtleties, might have resulted in the placement of a less demanding child and the provision of more effective casework help prior to the development of serious marital discord.

Tools and techniques

The complex process of selecting foster parents for emotionally disturbed children may require, in addition to the usual home study by a social worker, use of the diagnostic skills of other professional persons—specifically a psychologist and a psychiatrist. Having the prospective foster parents interviewed by a psychiatric consultant can be especially helpful, for, in addition to providing information about the applicants' emotional needs, the psychiatrist can appraise their ability to cope with anxiety-provoking situations.

In every instance, an imaginative, individualized approach is called for. New tools and techniques may also be needed. Perhaps there can be further refinement of useful psychological instruments, such as the sentence completion test described by Colvin.¹⁴

Experience has shown that discussion of each prospective foster family in a multidisciplinary staff conference can lead to a more unified, objective, and intensive understanding of the applicants. Such a discussion can help the caseworker arrive at an earlier identification of grossly unsuited applicants, move more confidently through the process of gathering and evaluating pertinent information, gain conviction regarding the importance of going into intimate

material with prospective foster parents, and recognize the transference and countertransference reactions which may develop during the home study.

The process of evaluating foster parents must not end at the conclusion of the study. On the contrary, there should be a continuing evaluation of each foster family's strengths and weaknesses in relation to their specific foster child as long as the child is in their home. The following example illustrates the importance of being aware of any new element which may make a foster family more vulnerable to stress.

Mr. and Mrs. C have worked with the agency as foster parents for 10 years, caring successfully for several emotionally disturbed foster children. Mary, their own 6-year-old daughter, an only child, has been very slow in her mental and physical development. Until recently, the C's have attributed the slowness of her development to the fact that she has a congenital heart malformation. But when Mary entered school and her limitations became more obvious, leading her principal to suggest that she be taken to a child guidance clinic, the C's equanimity was severely upset.

For the first time, the C's were forced to face Mary's problems. Their initial reaction was to project their feelings of being threatened onto their foster child, an aggressive 10-year-old boy. Although they had previously demonstrated unusual capacity for giving loving care to this seriously disturbed child and to tolerate his behavior, they suddenly had a great deal of difficulty coping with him. Wondering if he were not causing some of their daughter's problems, they began to consider requesting his removal from their home.

The caseworker intensified his support of the C's, and when they in turn reached out for further help, he encouraged them to discuss their own child's problems with him and with the psychiatrist. As the C's began to gain some insight into their ambivalent feelings toward Mary through these discussions, their anxiety was alleviated and they were able to accept a referral to a child guidance clinic. At the same time, they felt less threatened by the behaviour of the foster child, whom they again were able to handle with objectivity and competence.

Thus, by providing intensified service to a foster family at a time of vulnerability, the agency was able to help the foster parents successfully surmount a crisis without removal of the foster child. In this process, there occurred a strengthening of their roles as foster parents and a deepening of their relationship with the agency.

In conclusion

Further study is necessary to refine and validate many of the ideas expressed here. But there can be no question about the need to *know* prospective foster parents in considerable depth. This article has stressed the implications of certain pathological needs. Equally important, however, as criteria for

judging the capacity of foster parents for caring for a disturbed child are the healthy aspects of their personalities and the positive features of their request for a child.

The writer and his colleagues believe that some of the most important criteria in foster parent selection are: (1) The applicants' ability to cope with anxiety and to utilize it constructively; (2) their readiness to tolerate the need for personal growth within themselves and to permit the child to develop as fully and freely as possible; (3) their ability to avoid identifying the child too closely with experiences in their own past; and (4) their ability to use casework services.

We also believe that, as various authors have pointed out, selection of the most appropriate child for a foster home can be crucial to the success of the placement.^{1, 2} Such selection is based not only on a full understanding of the foster family but also on a thorough evaluation of the child.

Our experience has convinced us that it is possible to help certain emotionally disturbed children effectively through placement in foster homes. We recognize that at times such efforts can be frustrating and lead to serious questions about the use of foster family care for disturbed children.^{15, 16} We can only reiterate the confidence we have already expressed in the many families in our program who have exhibited sufficient strength to withstand the pressures of living with an emotionally disturbed foster child and to give an effective service.¹⁷ At the same time, we fully realize that the success of any placement is to a large extent dependent on the quality and quantity of services available to the child, to the natural parents, and to the foster parents.

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Healing hurt children through foster parenting is a vital social good—a necessity for many children and a necessity for a responsible public. It should not be limited by a notion that the foster parent should martyr himself to the job. The public should pay for foster care in terms of the effort and skill it requires.

Thomas M. Parham, Director, Division for Children and Youth, Georgia Department of Family and Children Services, to a 1965 alumni meeting of the University of Tennessee School of Social Work.

FAMILY AND CHILD WELFARE IN SOUTH VIETNAM

ELISABETH SHIRLEY ENOCHS

A strong sense of family unity and a capacity for self-help may be chief factors in sustaining the basic human values in thousands of Vietnamese families and children who have been uprooted from their homes by the exigencies of war. This impression, gained by the writer in a 2-week visit to South Vietnam last September, or the Agency for International Development (AID), U.S. Department of State, was strengthened by the report of a seven-man team, representative of American voluntary relief agencies, sent to Vietnam by AID in October. Both missions were undertaken as the result of a growing concern in this country about the welfare of the large numbers of children among the refugees, and the fear that Vietnam's need to provide care for war orphans might result in an increasing reliance on the institutional care of children.

It is difficult for people in the United States to grasp the extreme complexity of life in South Vietnam. The country has been at war for more than 20 years. At the same time, it has been trying to build or strengthen the basic institutions of a newly independent country. During the last decade, it has also had to resettle and absorb about a million refugees from North Vietnam. It has also had to deal with internal dissension, revolution, religious strife, and the constant need to move large numbers of rural people to urban centers or coastal regions because of the military situation.

Although it has never taken a census, the Government of Vietnam in 1962

estimated that more than half the population was under 20 years of age; that more than 81 percent lived in rural areas.

The refugees

Approximately 400,000 persons were living in refugee camps at the end of 1965—about 60 percent of them were children, 30 percent, women, and the remainder, aged or incapacitated men.

Not all the refugees are living in refugee camps—many have been taken in by relatives. Nor are all refugees fugitives from zones of combat. Because there is no dependents' allowance allotted to the families of Vietnamese conscripts, the wives and children of servicemen follow their menfolk from place to place. Also, many of today's "refugees" are victims of disastrous floods, still unable to return to their homes. On the other hand, attachment to one's own communities and the tombs of one's ancestors is so great in Vietnam that even the people who have fled from Viet Cong terrorism or from military activity try to return home as soon as they believe some security prevails.

Many refugees find employment on their own initiative. Small family industries appear. Many bring with them their simple tools and endeavor to ply their trades in the new location.

Noting "repeated evidences of strong family ties among the refugees," the AID-sponsored team reported:

... [the] refugees invariably moved in family, village, and hamlet groups

with recognized leadership that had authority in the camps and were an effective channel for assistance. Individual families and groups were frequently taken in by relatives in secure areas. Those in camps were observed cooking their own food and building their own huts.

Basic responsibility for care of the refugees rests with the Ministry of Social Action which provides an allowance of 7 piastres per day to adults (not quite 10 cents a day at the official rate of exchange), with an additional allowance in cash or in kind, usually condensed milk, for children under 2. The provision of condensed milk represents something of an innovation in infant feeding in Vietnam, where it has been customary among many rural families to breast feed children until they are 15 to 24, or even 36, months old.

The rural population of South Vietnam lives under conditions so primitive that the change to refugee status may represent less material hardship for many families than might be imagined. While recognizing the vast needs of many Vietnamese who have not been torn from their homes, the AID mission and a number of voluntary agencies are working with the Vietnamese Government to help these refugees preserve their strong family ties and native resourcefulness and to encourage their ability for leadership.

When I asked officials of the Ministry of Social Action what they needed the most, they mentioned four materials: (1) cement; (2) roofing; (3) calico; (4) *nuoc mam* (a widely used oily sauce extracted from fish). Cor-



In a refugee camp in South Vietnam.

rugated metal roofing is used for refugee housing, since part of the harassment of the Viet Cong has consisted of burning the vegetation used for the customary thatched roofs.

Education and training

On the nonmaterial side, the officials gave first priority to training opportunities for all categories of service personnel: doctors, nurses, teachers, social workers, midwives. Second was the need for more schools and for vocational training facilities.

The Government reports that it allots about 15 percent of its total budget to education and vocational training. Additional support for education is derived from foreign aid. According to estimates of the Ministry of Education, 65 percent of the children of school age in Vietnam enter school. About 40 percent finish primary school.

The director of the education division of the AID mission in South Vietnam tells a story that illustrates the Vietnamese determination not to let the war disrupt the educational opportunities of children. When military activity in the interior caused 11,000 people to be moved to a coastal region, almost the

first question raised was, "What about schools for the children?" Someone designed a shed for use as an emergency classroom. Someone else designed a more permanent type of structure. While the merits of the two designs were being studied, the local authorities in the region of resettlement had been busy making a survey of other possibilities. As a result, all existing schools in the locality, both public and private, were asked to take in as many refugee children as possible. Some additional buildings were located which could be adapted for classroom use. Only a very few emergency structures had to be built.

However, in some areas the local schools have not been so receptive to refugee children, particularly if they are from montagnard families.

Recognized dangers

Deep concern about the Vietnamese younger generation is reflected in a report prepared by various Vietnamese Government agencies for the Asian Conference on Children and Youth, scheduled to meet in Bangkok, Thailand, in March 1966, under the auspices of the United Nations Children's Fund (UNICEF), the Economic Commission for Asia and the Far East (ECAFE), and the Asian Institute for Economic Development and Planning. It says:

... The victims of battle leave behind them a steadily increasing number of orphans. In spite of the understanding shown by the authorities, government action to help these orphans becomes more and more inadequate as the military operations continue. Because of this the number of juvenile delinquents seems to be growing daily.

Moreover, the moral health of the country is severely impaired by the war which is being conducted in the countryside. Young people are confined to the towns where, idle and jobless, they have nothing to do with their time; bars and cafes are full and, as a result, rowdiness becomes proportionately more widespread. They should be given a worthwhile occupation to free them from the war psychosis they have lived in all their lives. Their morale should be improved and they should be given a sense of citizenship through education.

Vietnamese officials are especially worried about the "cowboys," by which they mean juvenile delinquents. They hope for the establishment of social centers and neighborhood houses where youth activities and adult education

programs may be conducted. One such center was recently opened in a Saigon slum by the school of social work sponsored by the Vietnamese Catholic agency, Caritas.

Child care

The United Nations has assigned child welfare consultant to cooperate with the Ministry of Social Action planning for children and youth, who has established a model day-care center in Saigon. The Government plans to establish 348 like it in Saigon and the provinces, with the hope of obviating the placement of young children in institutions. Many of the babies of young children now residing in Vietnamese orphanages have been brought to them by working mothers with large families who cannot remain employed if they have to take care of an additional child.

The Government also has plans to establish five orphanages. There are already over 70 orphanages in South Vietnam, 5 or 6 of them sponsored by Buddhist groups, and the rest mainly by Catholic organizations. Many of these institutions date back to the days of the French.

The orphanage at Than Duc, in Lo An Province, which I visited, is said to be typical. Located in the heart of the village, it shelters 66 girls and 53 boys ranging in age from a few months to years. It is run by four nuns belonging to a Vietnamese sisterhood. They are assisted by 10 lay helpers. The older children attend the village school; the younger, classes in the institution.

This institution is over 30 years old. The Bishop of Saigon contributes 5,000 piastres (\$60) monthly to its support. The Ministry of Social Action provides 1,500 piastres a month (\$21) and the American agency, Catholic Relief Services, contributes monthly 15 bags of flour, 25 bags of wheat, 5 cases of cooking oil, 8 bags of corn meal, and 5 cases of dried milk. Each month the nuns buy 240 kilos of Vietnamese rice. With the children's help, they raise pigs, ducks, chickens, and vegetables.

The institution contained only a few children who are actual war orphans. The mother superior said the children fell into three categories: (1) the "real cases"—children of very poor families where the father is dead or absent and the mother, with many children

A special consultant on social welfare for the Agency for International Development, Elisabeth Shirley Enoch, has for 10 years in international work with the Social Security Administration and for 24 years with the Children's Bureau, for 10 years as director of its International Division.

...nds it impossible to work and care for
...em all; (2) the "fatherless"—illegitimate
...children; and (3) the "true
...orphans." She said that children in
...the first category are not completely
...separated from their families. Their
...mothers continue to visit them. When
...the children reach working age, the
...mother or some other relative usually
...appears to claim them. Other children
...are helped to find employment when they
...leave the institution at the age of 16.

In Thun Duc, as in other institutions
...visited, there was an unusually large
...proportion of children with physical de-
...fects such as bare lip, cleft palate, and
...club foot. The nuns said that in Viet-
...nam such children are thought to bring
...bad luck and are therefore abandoned
...at birth to protect the rest of the family.
...Children are also abandoned if they are
...born on a day of "ill omen."

Another orphanage near Saigon, run
...by the same religious order, was caring
...for 721 children at the time of my visit.
...This institution was greatly over-
...crowded because it had admitted many
...children whose families had crowded
...to Saigon in search of work and se-
...curity and lacked living space for their
...large broods. Recent reports indicate
...that AID has helped to enlarge the in-
...stitution's plant.

Inquiries about the possibilities of
...adopting war orphans have come to the
...Government from Australia, but the
...Vietnamese do not look with favor on
...international adoptions, and adoptions
...are not easy under existing legislation.
...As far as the number of war orphans in
...children's institutions is small.

Efforts are being made to improve
...standards of institutional care. The
...United Nations consultant recently con-
...ducted an inservice training course for
...institutional personnel in cooperation
...with the director of the school of social
...work in Saigon.

When I asked officials of the Minis-
...try of Social Action whether considera-
...tion might be given to substitutes for
...institutional care, they replied that fos-
...ter care, if defined as the care of chil-
...dren in families other than their own or
...those of relatives, is alien to the cul-
...tural patterns of the Vietnamese peo-
...ple.

Many families are already caring
...for many of their kinfolk, and have no
...room for more, especially with the rising
...cost of living.

Nevertheless, an impressive demon-
...stration in keeping children out of insti-

tutions is being made by Foster
Parents Plan, one of the voluntary
agencies in Vietnam. This agency con-
centrates on helping families keep their
children at home rather than on child
placement. Its director reports that
the agency has been helping nearly 5-
000 families in Saigon and nearby
Cholon and plans on extending the
work to the provinces. Through a fi-
nancial sponsorship system, whereby
friends of the agency are asked to sup-
port specific families, children are kept
with their mothers or relatives and
casework services are provided the
family by graduate Vietnamese social
workers.

International aid

In addition to the United Nations,
many international social and health
agencies are active in South Vietnam.
UNICEF has equipped the first well-
baby clinic, in Saigon. From the
Philippines have come medical teams.
The work of the voluntary agency,
Foster Parents Plan, has already been
mentioned. This agency has also helped
the Vietnamese Women's Association
set up an emergency shelter in Saigon
for victims of the battle of Dong Xoai.

In addition, 17 U.S. voluntary

A refugee child in South Vietnam.



agencies are now working in South
Vietnam. Some of them are distribut-
ing commodities under the U.S. Food
for Peace program. CARE is helping
to increase the supply of *nuoc mam*.
Some agencies are providing medical
care and related services. Catholic
Relief Services, for example, has estab-
lished a small center in Saigon for the
care of crippled children, chiefly polio
victims. Some agencies—especially the
Mennonite Central Committee, the
Church World Service, and the
Lutheran World Relief—are engaged
in health and educational programs.
The International Voluntary Services is
helping with community development.

AID has established a refugee unit
in its Washington office and one in
Vietnam and recently recruited a spe-
cialist in child welfare to work in Sai-
gon. Many of the voluntary agencies
are also increasing staff, to meet a need
underscored in the report of the team
that visited Vietnam last October:

On all sides in Vietnam, we found
pleas for more personnel in a wide var-
iety of qualifications for work with
refugees. Food, material, and transpor-
tation problems are present, to be sure.
But these appeared manageable. What
was sought, however, was additional
people stationed in the field . . . to pro-
vide personal, individual services in
widely scattered camps, cities, and vil-
lages covering the whole range of wel-
fare activities for people in acute
need . . . These were requested un-
hesitatingly by Vietnamese government
officials, by U.S. civil and military officers,
and by the voluntary agency groups
themselves.

Graduates of the school of social
work in Saigon, operated by Caritas,
are in great demand in both public and
voluntary agencies. Founded in 1949
under Catholic auspices, the school has
45 students, all women, most of whom
are Buddhists. A second school of so-
cial work, emphasizing community de-
velopment, opened in August 1965 in the
Buddhist University, with an enroll-
ment of 250 students of both sexes.

Thus in combined efforts many agen-
cies, national and international, public
and private, are cooperating with the
Government and people of South Viet-
nam to contribute to the welfare of
Vietnamese families and children. But
the greatest hope for the children's fu-
ture may well lie in the strong sense of
family unity and the capacity for self-
help which have survived all the up-
heavals of the last 20 years.

HERE and THERE



Infant mortality

The infant mortality rate for the United States in 1964 fell to the lowest level on record, according to data gathered by the National Center for Health Statistics. In 1964 the rate was 21.8 deaths for infants under 1 year of age per 1,000 live births, a decrease of 2.7 percent from the average annual rate for the years 1960-62 and a reduction of 15 percent since 1950, when the rate was 29.2.

A Children's Bureau analysis of the 1964 rates shows that though the reduction in rate was significant for both white and nonwhite infants, the reduction for nonwhite infants was smaller. The pace of reduction in the rate for nonwhite infants since the period 1960-62 was -1.7 percent (from 41.8, the annual average rate in the years 1960-62, to 41.1 in 1964), as compared with a 4.4-percent reduction for white infants (from 22.6 to 21.6). Thus, in 1964 the rate for nonwhite infants was 90 percent higher than the rate for white infants as compared with 85 percent higher in the period 1960-62. In 1950, the infant mortality rate for the nonwhite group was 66 percent higher than for whites.

In 1964 the lag in reducing infant mortality for nonwhite infants was principally in the first month of life. The neonatal death rate showed no improvement for nonwhite infants, but rather an indication of increase (0.4 percent—from 26.4 deaths of infants under 28 days old per 1,000 live births in the period 1960-62, to 26.5 in 1964). The 1964 neonatal mortality rate for nonwhite infants was about 64 percent in excess of the rate for whites.

The overall postneonatal rate for infants 1 to 11 months old was reduced by

2.8 percent (from 7.1 in the period 1960-62 to 6.9 in 1964). Here the decrease was somewhat larger for nonwhite infants (-5.2 percent) than for white (-1.8 percent). Nevertheless, the postneonatal rate for nonwhite infants in 1964 exceeded the rate for white infants by 170 percent (14.6 per 1,000 as compared with 5.4 percent).

In considering fetal mortality and infant mortality together, the change in mortality rate in 1964 from the beginning of the perinatal period to the first birthday was slight, 40.5 fetal and infant deaths per 1,000 total births (live and still)—a 1-percent reduction from the period 1960-62, when the joint rate was 40.9.

The small drop in the joint fetal and infant death rate reflects a stationary—perhaps even an increasing—rate among nonwhite infants. For the white infants alone the reduction since 1960-62 was 2.8 percent. In 1964 the joint rate for white infants was about half the rate for nonwhite infants (35.1 per 1,000 total births in contrast to 67.4 among nonwhite infants).

Infant mortality rates by States ranged from 19.8 per 1,000 live births in Massachusetts to 39.4 in Mississippi. Fifteen States decreased significantly their infant mortality rates in 1964 over the average annual rates for 1960-62; 36 States had more or less stationary rates.

In cities which had populations of 500,000 or more in 1960, considered as a group, the infant mortality rate for 1964 was above national average: 27.9 in cities as compared with 24.8 for the country at large. The excess in the large city rate over the national rate was partly due to a higher death rate among white infants in the cities as compared with the national average for

white infants. For nonwhite infants in large cities, the rate—39.5—was below the national average for nonwhites—41.1. The infant mortality rate in these major cities rose 4.1 percent in 1964 from the rate in 1963 (27.9 as compared with 26.8). The principal increase was among nonwhite infants, of whom the rise was 7.6 percent (from 36.7 to 39.5).

—Eleanor P. Hu

Family planning

Late in January, Secretary John Gardner enunciated a policy for Department of Health, Education, and Welfare on population dynamics, fertility, sterility, and family planning signed to "improve the health of people, to strengthen the integrity of the family and to provide families freedom of choice to determine spacing of their children and the of their families."

As outlined in a memorandum to heads of the Department's operating agencies, the policy is "to conduct support programs of basic and applied research . . . to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department."

While under the policy, State and local agencies are to be informed of availability of funds for such programs; no pressure is to be put on them to participate nor is pressure "of mind or science" to be put on persons serving the programs supported or conducted by the Department.

* * *

Five nurses and midwives in key positions in Brazil, Guatemala, Liberia, Peru, and Uganda in mid-December completed a 3-month program of studies in maternal and child health and family planning, developed by the Children's Bureau under a grant from the Agency for International Development (AID) for foreign participants, the first in a projected series.

The program developed out of requests from the governments of the countries to AID missions for special

training programs for nurses and midwives who would eventually work in family planning services.

The first 4 weeks of the course, which concentrated on family planning, were also attended by nine U.S. nurses responsible for nursing in maternal and child health programs at State, county, or municipal levels of government.

The major part of the program was held at the Graduate School of Nursing of the New York Medical College. Other agencies and institutions which participated in the program included the Planned Parenthood-World Population Federation, the Population Council, the Ford Foundation, the National Council of the Churches of Christ in the U.S.A., the rhythm clinic of the St. Vincent's Hospital in New York, the New York City Health Department, the New York Hospital-Cornell University School of Nursing, the Pan American Health Organization, and the United Nations Food and Agriculture Organization.

The program began for the foreign participants with orientation at Washington's International Center and concluded with a seminar on the communication of skills and ideas, held at Michigan State University, both sponsored by AID.

The program had six major objectives:

1. To bring up to date the participant's knowledge and understanding of the biology and physiology of human reproduction.
2. To identify the role of the nurse in family planning.
3. To examine attitudes toward and the problems of population control and growth.
4. To provide opportunities for clinical observation of contraceptive methods.
5. To review human nutritional needs, especially those of pregnant and nursing mothers and of preschool children. To this end, the program included a seminar on the nutritional needs of mothers and children around the world.
6. To review the use of patient and family health service records and biostatistical data to improve the care of individual patients and families and to plan ways of meeting existing and new health needs. Data on the fundamental health needs of each country represented, brought to the

program by each participant, were used as a basis for developing discussions.

Using the first program as a guide, a second program for nurses from Turkey is being planned at that country's request for the summer of 1966.

For youth

Two years of experience with STAMP (Student Tutoring and Motivation of Parents), a project of help for neighborhood high school students and their parents, have led the Carver Community Center of Schenectady, N.Y., its sponsor, to plan to extend the project from a few selected students and their parents to all students and their parents in the neighborhood who want help. For several years before setting up STAMP, according to Mrs. Charles Allen, project supervisor, the Carver Community Center had sponsored a program of individual tutoring for students without notable success. Project STAMP grew out of the belief of workers at the center that lack of motivation at home was responsible in many cases for the failure of tutoring.

In conducting STAMP, the center selected 20 students at random from the seventh, eighth, and ninth grades of one school, all with IQ's in the normal range and poor reading scores. Half took part in the experiment; the other half acted as a control group.

Student in both groups received individual tutoring in two subjects by volunteer tutors, all of whom were college graduates. The difference was that the parents of the students in the experimental group were brought into the project.

STAMP's supervisor visited the families of the students in the experimental group at least every other week. Parents—usually only the mothers—attended group meetings twice a month. As the project progressed, the emphasis of the group meetings was on extending the mothers' horizons, both educationally and culturally, rather than on having the programs predominantly centered on the child. The success of including attendance at a play in the first year's program led to the inclusion of other cultural activities such as opera and a concert in the second year's.

At the end of 2 years, the project worker found that the grades of the students in the project had improved more than those in the control group.

In evaluating the project at the end of each year, the mothers said that the project had been helpful and that they believed their children had enjoyed taking part.

The project had other positive results, too, according to Mrs. Allen. In working with the parents, workers found that nearly all families needed social services of some kind. Many serious problems kept the parents from helping their children. Whenever possible, the project worker referred families to agencies that could help them.

The project has been financed by the Junior League of Schenectady and the New York State Division for Youth.

Child welfare

A review schedule for evaluating the intake process in child welfare services, prepared by the Children's Bureau, has recently been distributed to State child welfare agencies. The purpose of the schedule is to help public welfare agencies conduct systematic reviews of the intake process in child welfare cases, in order to improve their services.

The schedule defines "intake process" as all activities—including emergency service, social study, and diagnosis—for a child, from the time the child is brought to the agency's attention to the selection of a plan for service, whether protective services, other services for children in their own homes, services for unmarried parents, adoption, foster family care, group or institutional care, day care, or homemaker service. The intake process is particularly important, according to the instructions accompanying the schedule, because the decision made at the time of these activities affect all subsequent service.

The Bureau, which is working through its regional staff to help State public child welfare agencies apply the schedule during this introductory year, is recommending that it be used in a limited number of localities before being applied in statewide reviews.

* * *

The Extension Division of the University of Wisconsin has completed the preparation of guide material for a 17-week correspondence-discussion course designed to train child-care workers at children's institutions. Discussion leaders, to be selected from different regions throughout the United States,

will give the course under the close supervision of the university. The course consists of 2-hour discussions each week, written assignments, and required reading.

The project to develop guides for the instructor and materials for the child-care workers has received financial support from the Hecht-Parents' Magazine Foundation for Child Welfare, Inc., with the endorsement of the Children's Bureau. The Bureau will soon be working with State licensing agencies, national organizations, schools of social work, and universities to plan for and test the correspondence course.

Children's institutions

The most nearly complete, inclusive, and up-to-date listing of residential institutions for children in the United States has been compiled by the Center for Urban Studies of the University of Chicago for use in its current research on the adequacy of present physical facilities for group care of children. Shirley A. Star is director of the study, which has received a Federal child welfare research grant from the Children's Bureau.

Each State was asked to report every separate facility providing residential care for 6 or more persons under 21 but only for persons under 21. Medical facilities for acute or short-term care, summer camps, and purely educational boarding schools were not included.

Under these definitions, 3,763 institutions and group homes for children were listed in September 1965. Forty percent (1,515) of these were classified as institutions for dependent and neglected children, including temporary shelters. Other categories, in order of number of listings, were residential facilities for mentally retarded children (701, or 19 percent); institutions or detention homes for delinquent children (647, or 17 percent); residential facilities for physically handicapped children (373, or 10 percent), and for emotionally disturbed children (315, or 8 percent); and maternity homes for unmarried girls (212, or 6 percent).

Nearly all the detention facilities, 80 percent of the psychiatric inpatient facilities for children, 69 percent of the institutions for delinquent children, and 55 percent of the temporary shelters were under public auspices. On the other hand, nearly all the maternity

homes, 85 percent of the residential treatment centers for emotionally disturbed children, and 78 percent of the institutions for dependent children were under voluntary auspices.

Of 562 group care facilities classified as proprietary, 74 percent were for mentally retarded children. The majority of the latter were in California. Sixty percent of all facilities for retarded children were under proprietary auspices, 22 percent under public auspices, and 18 percent, voluntary.

Cuban children

A total of 258 of the 1,500 Cuban children who on December 1, 1965, were in foster care under the U.S. program for unaccompanied Cuban children were reunited with their parents during the first 10 weeks of the airlift provided by the U.S. Government for would-be Cuban emigrés under agreement with the Cuban Government. Many of the reunions were made possible by the decision, announced by President Johnson last October, that first priority in the airlift program would be given to parents of Cuban children already in this country. As a result, the airlifts through February 10 brought 442 parents—177 couples and 88 lone parents—of 338 of the children in the foster-care program.

Because during the period a few other children were discharged to relatives and friends or were dropped from the program having reached the age of 19, the program had only 1,319 children in care as of February 1. Since the airlifts were taking place at a rate of two a day, an accelerated reduction was anticipated. Plans are to return all children whose parents reach this country to their parents as soon as appropriate arrangements can be made.

At least 13,000 children are known to have come to this country unaccompanied by either parent since late 1960—most of them sent by their parents. Of these, nearly 8,000 have received foster care, arranged by a variety of voluntary agencies, under the Federal program for unaccompanied Cuban refugee children. The program, which was inaugurated early in 1961, is a part of the Cuban Refugee Program of the Department of Health, Education, and Welfare and is administered by the Children's Bureau through the Florida State Department of Public Welfare.

(See "Cuban Children Away from Home" by Kathryn Close, CHILDREN, January-February 1963.)

Education

In the fall of 1965, public elementary and secondary schools enrolled 42 million children, an increase of 727,000 or 1.8 percent over the previous fall according to the 1965 statistical survey of public schools made by the U. S. Office of Education. The increase was greater in secondary than in elementary schools. The 15.7 million pupils enrolled in secondary schools in the fall of 1965 represented an increase of 533,000 over the previous fall; the 26 million pupils enrolled in elementary schools represented an increase of 194,000.

The survey also showed that the supply of public school teachers increased by 4.1 percent, rising from 1,648,000 to 1,716,000, decreasing the ratio of pupils to teachers from 25.1 to 24.6. The number of teachers with substandard certificates, 81,748, represented a slight decline from the previous year.

The Office of Education estimated that the total expenditures for public schools in the current school year (1965-66) will be about \$25.8 billion.

With the exception of one institution in Mississippi, all State colleges and universities in the 17 Southern border States and the District of Columbia were racially desegregated in practice or in policy by the end of 1964 according to recent figures from the Southern Education Reporting Service. At the elementary and secondary school levels, desegregation was farther from completion, the figures indicate, 14,804 of the region's 5,372 school districts had submitted plans for desegregation under the Civil Rights Act of 1964 acceptable to the U.S. Office of Education and were considered in graded in principle.

In actual figures, however, only small number of Negro students at these levels were attending classes with white students in the 11 Southern States. As far as the Service could determine, about 200 Negro students were attending colleges with white students in Alabama. In Mississippi there were no Negroes attending junior colleges with white students, though

Negroes were attending formerly all-white State universities. In Florida an estimated 7,612 Negro students were attending junior colleges with white students. About the same number of Negro students were attending colleges with white students in North Carolina. However, the actual number of Negro and white students involved in college desegregation is uncertain, the Service points out, because many States no longer report statistics by race.

At the elementary and secondary levels, the Service reports that actual integration was very slight in the Deep South, but moving toward completion in at least four of the border States and the District of Columbia. Less than 1 percent of the Negroes enrolled in schools in three Southern States—Alabama, Louisiana, and Mississippi—were going to the same schools as white children. Texas had the highest rate

for the region—17.2; Tennessee was second with 16.3 percent. In Delaware, the District of Columbia, Kentucky, Missouri, and West Virginia, desegregation was at least 75 percent complete.

A report on figures through November, entitled "Statistical Summary of School Segregation-Desegregation in the Southern and Border States, 1965-66," is available from the Service, Post Office Box 6156, Acklen Station, Nashville, Tenn., 37212. Price: \$1.

* * *

"Roundabout," a series of 15-minute television programs aimed at helping disadvantaged, preschool children to understand their environment, went on the air in Washington, D.C., in December 1965. Produced by the educational television station WETA and the United Planning Organization (UPO), the planning agency for Washington's anti-

poverty program, the series is being shown in model preschool programs sponsored by UPO and the District of Columbia Public Schools and in church, cooperative, and settlement-house nursery schools. It is financed by a grant of \$208,878 from the U.S. Office of Education.

The performers on "Roundabout" are children who live in a depressed area of the city. There is no central figure, though a young man, a kind of big brother or father figure in the script, provides continuity.

Plans call for 104 episodes. Those shown so far have dealt with such topics as modeling with clay, how hinges work, and how a house is put up.

UPO and the Board of Education of the District of Columbia plan to conduct evaluation studies of the films' effectiveness with a selected group of children.

in the journals

families on AFDC

Arguing for intensified research efforts to discover the true characteristics of families in the program of aid to families with dependent children (AFDC), Henry Miller, in the December 1965 issue of the quarterly *Social Service Review*, maintains that such research has been slight and the results conflicting. ("Characteristics of AFDC families.")

One study he cites indicates that the incidence of juvenile delinquency is higher among families in the AFDC program, another that it is lower; one study indicates a high rate of alcoholism among AFDC family heads, another that it is lower than in the population as a whole.

Greater knowledge about the characteristics of families in the AFDC program is needed, the author says, as a basis for planning rehabilitation services—but not for justifying the spending of public funds for their maintenance, for this calls only for the knowledge that the fathers are absent or

incapacitated and the families poor, and he cites data indicating how poor. He recommends that the research be focused on specific localities rather than generalized, because the characteristics and problems may be different in different places.

Negro families

Challenging the view that there has been a recent rapid deterioration among Negro families, Elizabeth Herzog, in the January 1966 issue of the quarterly *Social Work*, maintains that what is new in the Negro population is "an injection of hope that attacks apathy and fatalism and sparks insistence on full justice." ("Is There a 'Breakdown' of the Negro Family?")

Granting that "fatherless families" are proportionately more prevalent in the Negro than in the white population, the author cites census figures back to 1949 indicating that the rate of broken homes in the Negro population has only gradually increased and not suddenly accelerated. She blames their greater

prevalence among Negroes not on a "legacy of slavery" but on "post-slavery factors of deprivation and discrimination affecting every facet of [Negro] life: occupation, education, income, housing, nutrition, health and mortality, social status, self-respect . . ." The cure, she maintains, is "jobs for Negro men—jobs with status, with stability, with future, and with fair wages."

Suggesting that "the" Negro family is a fiction, Miss Herzog asserts that "different family forms prevail at different class and income levels throughout our society," and cites studies showing a high prevalence of broken homes and illegitimacy among poor white families.

With the warning that "problem-focused discussions" invite distortion, the author points out that even among the poor, two-thirds of the Negro families have the father present. She concludes with the plea that greater attention be given to mobilizing the sources of strength among the Negro poor.

Well-baby clinics

In relation to well-baby clinics "we still stand today on the same threshold which held such promise 30 years ago," Samuel J. Braun, M.D., says in the December 1965 issue of the *American*

Journal of Public Health. ("The Well Baby Clinic: Its Prospects for Building Ego Strength.") There are several fundamental problems that still require solution, he maintains; for instance, how the clinics can reach the many people for whom they are intended, and how to provide continuity of care.

There is little integration in practice of the information gained by the various staff members in well-baby clinics, the author also maintains, even though "common sense" points up the importance of the well-baby clinic to the child's future health and well-being. Much too frequently, he asserts, the public health nurse has carried the responsibility for well-baby care and counseling by herself, "with the exception of the '3-minute' hour contributed by the physician." It is time, he maintains, to support the public health nurse's "valiant singlehanded efforts" and to give her the "wholehearted support of the physician in carrying out the aims and purposes of the well-baby clinic program."

The author maintains that clinic workers have emphasized the one-to-one approach between client and staff members at the expense of a group approach.

Safety first

Preschool children from highly disorganized families, exposed to neglect, extreme and vacillating discipline, and even abuse, develop abilities to cope with their environment at an early age, Charles A. Malone, M.D., maintains in the January 1966 issue of the *American Journal of Orthopsychiatry*. ("Safety First: Comments on the Influence of External Danger in the Lives of Children of Disorganized Families.") However, he adds, these abilities derived from the need to avoid danger are a source of weakness as well as of strength. He bases his conclusions on a study made in a therapeutic nursery school of 21 children from disorganized families living under extreme slum conditions.

The children, the author reports, were quick and agile, but mistrustful. Their conduct at the nursery school reflected guarded fearfulness. At the same time, they showed advanced ability in such tasks as caring for infants and doing simple grocery shopping. But such abilities, the author re-

ports, did not represent "an internal adaptive capacity, but rather a premature coping pattern learned by rote." He found the children bound to external stimuli; their bondage contributing to "rigid literalness" in their learning.

Preschool experiment

In an effort to find out whether the presence of an adult male in a nursery school could help break the "female-dominated environment" of many classrooms, the University Laboratory School, University of Hawaii, placed four boys, seniors at the university's high school, in each of four nursery schools for 45 minutes a day in the first semester of this school year (1965-66). According to a report on the project in the January 1966 issue of *Childhood Education*, the nursery school was selected on the assumption that in it "the preschool child is probably at the best age to benefit from benign male influence . . ." ("Young Men in a Nursery School," by Will Kyselka.)

At the time the article was written, the author points out, the project was still too new (15 weeks) and too limited for positive results. He reports, however, that the boys were enthusiastic and there seemed to be evidence that the children had benefited.

The article is mainly a report on the experience of the boys who, in addition to keeping daily logs, met with a supervisor from time to time in groups and individually. At first, the boys reported, they felt "awkward and unnatural" though the children paid little attention to them. In a few days, though, they were accepted by the children with whom they romped or read stories to, all within the class routine.

The author says the boys took the assignment very seriously. Said one, "Right now it is a very satisfying experience for me because I'm having fun, but I'd like to know if it is really helping them."

The one-parent child

The child who loses a parent, either by death or divorce, must be helped to overcome his feeling of guilt for not having prevented the loss of the parent, Kurt Freudenthal says in the December 1965 issue of the *Single Parent*. ("The Only Parent.") The child's need for reassurance can be overwhelming, and

"it must be met if the child is to grow up with a sense of security and a belief in himself as a worthy person."

The author maintains that it is helpful to a child to keep alive the memory of a deceased parent and of how much the child meant to him. The child can not be protected, he says, by removing reminders of the dead.

Divorced parents can ease the situation for their child, the author maintains, by continuing to let him know he is loved.

The well-being of the child, he says also may depend on his maintaining a favorable image of himself and both parents, particularly of the parent of the same sex. He warns that to close relationships with a single parent, particularly if of the opposite sex, "should be viewed with real concern since they may permanently impair the child's ability to function well in later personal relationships."

Welfare law publication

The *Welfare Law Bulletin*, a monthly 8-page information bulletin sponsored by the Project on Social Welfare Law of the New York University School of Law, made its initial appearance in December. According to an announcement in the first issue of the *Bulletin*, it will collect and disseminate information in the field of "welfare law." In addition to brief, signed articles, it will carry notes on court decisions, administrative decisions, regulations, statutes, law review articles, and publications and projects concerning the law and welfare.

The first issue describes the Project on Social Welfare Law of the New York University School of Law and the Center on Social Welfare Policy, a Law at the Columbia University School of Social Work; comments on recent decisions having a bearing on public welfare administration, including decisions having implications for assistance recipients' right to privacy and for the interstate placement of juveniles; and reviews four new publications on the legal rights of the poor.

The *Bulletin* requests that material on cases pending in courts and administrative offices of public welfare agencies be sent to Mrs. Gertrud Mainzer, Project on Social Welfare Law, New York University School of Law, Washington Square, New York, N.Y., 10003.

BOOK NOTES

SENSING OF FAMILY HOMES IN CHILD WELFARE: a guide for instructors and trainees. Lela B. Costin and Jennette R. Gruener. Wayne State University Press, Detroit, Mich. 1965. 155 pp. \$4.95.

This training guide grew out of a project, supported in part by a Children's Bureau grant, to train college graduates who have had no previous training or experience in social work, the licensing of independent day-care or full-time foster homes. It is based on the tasks of the licensing worker seen as essential by supervisors of practicing licensing workers who participated in the project. [See pages 68.]

Presented in the form of a course outline, the guide is divided into eight parts: (1) licensing—a basic service; (2) statutory basis of licensing; (3) standards and standard formulation; (4) growth and development of the child in the family; (5) the licensing process; (6) differential aspects of family home licensing; (7) community organization aspects of child-care licensing; and (8) the philosophy of licensing. Appendices present and analyze the legal foundations for the licensing standards in Illinois and Texas.

While the guide's chief purpose is to meet the needs of the licensing worker licensing independent foster family homes, the authors maintain, in the introduction, that it will also be useful in the training of nonprofessional workers studying family homes sponsored by social agency.

The authors are both on the faculty of the Jane Addams Graduate School of Social Work, University of Illinois, Chicago.

THE INDIVIDUAL, SOCIETY, AND HEALTH BEHAVIOR. Andie L. Nuttson. Russell Sage Foundation, New York. 1965. 533 pp. \$6.50.

Primarily a text for schools of public health, medicine, and nursing, this book is with man as a member of society

and his behavior in relation to public health. In the preface, the author, a professor of behavioral sciences at the School of Public Health, University of California, Berkeley, says that he has tried to "unite theory, research, and practice in a way meaningful to the public health practitioner." To this end, he pretested each chapter with "public health colleagues in lectures, seminars, consultations, and discussions," and then added new material.

The book reviews current social-psychological knowledge and theory relating to basic behavior, describes problems of health research, and points out problems needing further investigation. It is divided into sections on the general characteristics of man, man in his social environment, social motivation, human learning and health action, and the communication process.

In a chapter on the "crisis in medical communication," the author maintains that the gap between scientific knowledge and its use grows wider. This, he says, creates "an urgent need to identify, evaluate, and interpret research findings currently available for immediate use in public health practice," and also "to communicate such knowledge effectively in order to elicit improvement in public health behaviors."

READINGS IN CHILD DEVELOPMENT AND PERSONALITY.

Edited by Paul H. Mussen, John J. Conger, and Jerome Kagan. Harper & Row, New York. 1965. 480 pp. \$4.95.

The 31 contemporary "essays and empirical papers" in this anthology are grouped under six main sections covering biological factors in development during children's early years, early interaction of infants with environment, socialization in the preschool years, early cognitive development, behavioral differentiation (family and social influences), and adolescence.

The volume contains two previously unpublished papers: "Information Proc-

essing in the Child" (Kagan) and "Antecedents of Delinquency: Personality, Social Class, and Intelligence" (Conger, Miller, and Walsmith).

The collection is keyed to the major themes discussed in the second edition of an earlier book written by the co-editors, "Child Development and Personality."

THE FAMILY AND INDIVIDUAL DEVELOPMENT. D. W. Winnicott. Basic Books, New York. 1965. 181 pp. \$5.

The central topic of "The Family and Individual Development" is "the family, and the development of social groups out of this first natural group." It is a collection of 18 lectures given by the author, child psychiatrist at Paddington Green Children's Hospital in London, mostly to groups of social workers.

The first 11 lectures, grouped as part 1, discuss such topics as the emotional development in the first year of life, growth and development in immaturity, security and the young child, integrative and disruptive factors in family life, the 5-year-old child, the effects of psychotic parents on the emotional development of the child, adolescence, and the family and emotional maturity.

In the lecture on adolescence, subtitled "Struggling through the Dolls' Drums," Dr. Winnicott asserts that nearly all countries today have adolescent groups "making themselves evident in some way or other," and suggests that it might be a sign of a society's health that its teenagers are able to be adolescent at the right time—at puberty. Pointing out that adolescence is a time of personal discovery, he maintains that the adolescent does not want to be understood, and that the only cure for the condition is the passage of time: "Society needs to include this [adolescent dolls' drums] as a permanent feature and to tolerate it . . . to come to meet it, but not to cure it. . . ."

The last seven lectures, grouped as part 2, discuss such topics as advising parents, casework with mentally ill children, deprived children and compensation, and the meaning of the word "democracy."

In regard to democracy, Dr. Winnicott maintains that the best way to promote the democratic tendency is negative action: avoid interfering with the ordinary good home.

READERS' EXCHANGE

GARRETT et al.: More "exchange" needed

Many thanks to Beatrice Garrett and to the describers of several innovative programs for their contribution to foster care through the January-February 1966 issue of CHILDREN. ["Meeting the Crisis in Foster Family Care," by Beatrice L. Garrett, and ensuing program descriptions by Mother M. Ann Michaela, Aileen B. Ostazeski, Elizabeth A. Lawder, Vivian Hargrave, and Catherine Pratt.]

More articles like the ones in this group are needed to shake us out of our traditional and inadequate ways of trying to meet the needs in foster family care. One *hears* of new ways of working with groups, interesting experimentation in staff utilization, creative uses of volunteers, consciously planned long-time foster care, agency-owned treatment family homes, subsidized adoptions, auxiliary helps to the foster family, and a variety of methods to give recognition to foster parents as part of the treatment team. These experiences need to be documented, if only in capsule form. Why isn't the Readers' Exchange section of CHILDREN being fully used for sharing what is really going on throughout the country?

The articles, challenging as they were, failed to mention one important point—the cost of some of the innovation. The high per capita cost could very well be the most serious impediment to adopting creative plans. Somehow, we have to get the boards and public budgeters to accept the fact that foster-care costs, like all others, are bound to increase. If anyone has found answers to that money question, the details should be broadcast immediately!

Roman L. Haremski
Deputy Director
Illinois Department of Children
and Family Services

Editors' Note: We heartily concur in Mr. Haremski's suggestion that inno-

vators share their experiences with others through this Readers' Exchange, and we hereby broaden the invitation to include not only those in the field of foster care, but in all kinds of services for the health and welfare of children.

POLIER: Re parental rights

Justine Wise Polier's thought-provoking article in the November-December 1965 issue of CHILDREN ("The Invisible Legal Rights of the Poor") raises the issue of the termination of parental rights in the case of children in institutional or foster family care whose parents fail to make reasonable plans for the child's return home.

Additional and serious consideration needs to be given to the question of parental rights in respect to the illegitimate child who is placed in foster care practically from birth. In this connection, we need to reconsider our current practice in offering child placement services to the unmarried mother—the only parent in the picture in many foster-care cases. Many unmarried mothers who seek such service are still in their teens and others are very immature. Many are the products of deprived and broken homes. Though unable to provide a home for their infant, they are usually beset by guilt at the idea of giving up the child.

In a praiseworthy attempt to help such a child-woman mature and provide for the infant what mothering she can, all too often the caseworker plays right into the girl's ambivalence and guilt configuration, by helping her to plan for foster care for the infant she is unable to relinquish. In this way, the mother can both hold on to the child by not relinquishing him for adoption and yet effectively give him up, through the more socially acceptable plan of foster care. Of course, both the social worker and the mother continue to hope that she will some day be able to provide the child with a home, but this is a wish-fulfilling fantasy rather than a reality in the great majority of cases.

In this type of case, the infant, if is lucky, may be placed in some sort "short-term" foster home. Unfortunately, the infant has no way of conceptualizing such abstractions, and cannot distinguish "short-term" from "long-term." When, therefore, it comes obvious somewhere in the child's second year, or later, that he is going to need foster care for an extended period of time, and a replacement is made, he is unable to comprehend the growth logic of the change, and must feel that his world has been shattered, which indeed it has been.

Because of factors encompassing both the threat to the child's feeling of security, closely tied up with the first foster "mother," and the immense potential this "mother" has at this point for alienating the child, it seems to me that there is no such thing as a "good" short-term plan for an infant, and that such a plan should only be resorted to under extreme circumstances, and never as a matter of almost routine policy as in the case of illegitimate children.

I am not overlooking the fact that we are dealing with an area of great social concern in which changes are difficult to make and may have far-reaching effects. There has been a natural, deeply rooted reluctance to tamper with the rights of natural parents, in this case the natural mother. However, we are dealing here not with "natural right" in the original meaning, but rather with a fringe area of parental rights in foster care created through the very provision of foster-care services, which have made possible the assumption of rights without the assumption of any responsibility for the care of the child.

In this area, as in many others, action is really a positive act. Our continued unwillingness to face the issue and take a stand has immense repercussions for children in foster care.

Monica Friedland
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New York

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JUVENILE DELINQUENCY—FACTS, FACETS: the institutional care and treatment of older hyperaggressive delinquent children. George H. Weber and Raymond L. Manella. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. No. 19. 1965. 9 pp. 15 cents.

This 19th document in the Children's Bureau series on juvenile delinquency discusses the problems faced by institutional and State agency administrators in legal, administrative, facility, and program planning for extremely aggressive older delinquents who do not respond to the basic patterns of institutional care and treatment. It cites factors which in recent years have intensified the difficulties in the task of treatment and rehabilitation, among them, the greater hostility in children admitted to institutions.

JUVENILE DELINQUENCY PREVENTION IN THE UNITED STATES; and THE CONTROL AND TREATMENT OF JUVENILE DELINQUENCY IN THE UNITED STATES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau.

1965. 60 pp.; 36 pp., respectively. Single copies available from the Bureau without charge.

Two reports prepared for the Third United Nations Congress on the Prevention of Crime and Treatment of Offenders, held in Stockholm, Sweden, August 9-18, 1965. The first discusses the social forces behind the expanding juvenile delinquency problem in the United States and describes the interrelated efforts of Federal, State, and local agencies to develop and refine comprehensive preventive programs, with special emphasis on programs established under Federal legislation enacted since 1961.

The second report discusses the roles of police, detention care, probation services, group treatment programs, camps, and parole supervision in the control and treatment of delinquency.

CHILD WELFARE STATISTICS— 1964. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Statistical Series No. 82. 1965. 43 pp. Single copies available from the Bureau without charge.

Through 40 tables and text this publication presents 1964 statistics for indi-

vidual States and the country as a whole on children receiving various types of child welfare services from public and voluntary agencies and institutions, licensed day-care facilities, and children provided care in such facilities; public child welfare agency personnel and salaries, and personnel granted educational leave; expenditures from Federal, State, and local sources for public child welfare services; and 1963 statistics on children for whom adoption petitions were granted.

It points out that of the 652,000 children who were receiving child welfare services on March 31, 1964—5 percent more than on the same date in 1963—68 percent were being served primarily by public agencies or institutions. Two-fifths of the total number were living with parents or relatives; nearly one-half were in foster care; and one-tenth were in adoptive homes.

SERVICES FOR CHILDREN: How title V of the Social Security Act benefits children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Fact Sheet. Revised 1965. 16 pp. Single copies available from the Bureau without charge.

Written in question and answer form, this pamphlet describes the nature and purposes of grant programs administered by the Children's Bureau under the Social Security Act to provide for maternal and child health services, services for crippled children, child welfare services, and demonstrations and research relating to such services.

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children

AN INTERDISCIPLINARY JOURNAL FOR
THE PROFESSIONS SERVING CHILDREN

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Legal Rights in Protective Services

Helping Disorganized People

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How People and Statistics Differ



children

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Mother and child in a clinic waiting room. The patience and love suggested by their attitudes are reminders of the "long experience in coping with problems of survival" that comes with being poor (see pages 104-108), and of the strength in individuals which may be overlooked when generalizations are made about the "culture of poverty" (see pages 99-103).

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In 1964, while preparing draft legislation for Connecticut's program of protective service I became convinced that adequate legal procedures for implementing such programs, there are in other States, were being forgotten in the growing concern over child neglect and abuse, and that the brushing aside of a legal apparatus designed to insure reasoned decision-making might have serious consequences, not only for the social work profession but also for people caught in the State's machinery for dealing with child neglect. What follows is an attempt to suggest some basic questions and statutory provisions which could resolve them.

Protective services are more easily described than defined. In carrying them out, a social agency receives neglect referrals from police, schools, court neighbors, physicians, and other social agencies. Then, the agency sends a social worker to the family home. He confronts the parents with the community's concern and tries to learn about the quality of child care they do, or could, provide. When the care is inadequate, the worker offers to help the family through social work counseling, to improve the parental qualities and so to avoid juvenile court action and possible loss of their children's custody. The social worker may continue to see the family for a short period, or indefinitely, depending on the situation. He is not empowered to remove the children from the home, but if he thinks the children are in danger, his agency may petition the court for their removal.

This type of service has been called "authoritative reaching out" because it is part of the State's authoritative response to neglect, furnished to parents who have not requested it. The establishment of such a service has grown out of the long-time recognition that juvenile court action treats only the terminal stages of neglect and so is too little and too late.

Several excellent studies of protective services have demonstrated that approximately two-thirds of the families served improve sufficiently to make formal court action unnecessary. Such programs represent a move toward alleviating the social cost of neglect and thus justify an authoritative approach in effort to stimulate parental change.

The legal problem

In States having no legislation authorizing protective services, some form of juvenile court act provides the sole authority for the State to intervene in cases of neglect. Under juvenile court laws, a parent

SAFEGUARDING LEGAL RIGHTS IN PROVIDING PROTECTIVE SERVICES

egged to be neglectful is protected from State power
the requirements of due process of law. The par-
t is given notice of the neglect petition, is entitled
a hearing at which he can contest the truth of the
negations before a judicial officer, and is protected
om ill-founded action by the rules of evidence and
her court procedures. Finally, if the facts alleged
the petition are proved, the court must decide on a
position of the case in accordance with alterna-
tives provided by statute. Frequently the parent is
owed to retain custody of the child subject to the
pervision of a probation officer.

In protective services, the social worker is part of
administrative agency, separate from the juvenile
court and empowered to provide the type of supervi-
sion to the home that a court may order, but solely
the basis of a social study in which legal considera-
tions may be absent. The standards of care expected
the family under this supervision are set by the
agency at its own discretion and may vary as the
needs of therapy require. Moreover, the agency's
criteria for intervention can be based on a lesser de-
gree of neglect than is necessary to sustain an adju-
dication of neglect in the juvenile court; for the pur-
pose of protective services is to treat incipient neglect
and to resort to the court only when effective treat-
ment has proved to be impossible.

Neglect," however, is a concept which permits no
degree of certainty, either in legal definition or social
application. Most neglect statutes are broadly
drawn. Such phrases as "proper care" and "condi-
tions prejudicial to a child's well-being" define the
conditions on which the State may act. These stand-
ards do no more than import vague subjective tests
to a legal criterion. Commentators on the juvenile

court generally agree that protection from this
vagueness must be found in the wisdom of judges
rather than in the detail of statute. But they also
recognize that the vagueness "enables judges to con-
ceal any kind of result behind . . . pious intona-
tion(s) . . ." and "encourages slipshod decisions
which stop short of workmanlike analysis and the
decision of important legal issues."¹

Even when judges try to articulate a legal or social
criterion of neglect, which could be a guideline for
a protective worker, the results are not uniform.
Judicial standards for parental care range from a
"reasonably prudent man" test carried over from the
law of negligence² to a "demonstrated incapacity or
something akin to criminal neglect."³ Perhaps the
standard most generally followed is, as Monrad
Paulsen suggests, the minimum quality of care which
the community will tolerate.⁴ One judge, in a well-
justified dissent, said that a decision should be based
on "all of the many-colored hues going to make up
the spectrum of life."⁵ Thus there is no agreement
on the fundamental question of what standard of care
the law requires of parents.

To make matters worse, there are almost no writ-
ten juvenile court opinions dealing with neglect, and
few appellate decisions. Thus a protective worker
in determining whether to refer a case to court must
rely on his personal or hearsay knowledge of what
the judge has done in the past. Conversely, juvenile
court judges frequently have to base a decision on
their evaluation of the professional soundness of the
social worker presenting the case rather than on the
facts alleged in a social study.

Social work as a profession does not provide any
clearer criteria. Its emphasis on the emotional and

psychological well-being of the child makes social workers less likely than many judges to interfere with family life on the basis of such forms of value preference such as religion or political beliefs. But their goal of emotional well-being is also based on value preferences.

A social worker may assume for himself a hierarchy of social values and conclude that families are providing children with what they need if they are, for example, adventuresome and generous, motivated by a desire to foster social responsibility, and endowed with spiritual qualities. But such values make precision in goal definition impossible.

Edith Varon once asked five field workers and three supervisors in Massachusetts what criteria their agency used in selecting cases for protective intervention. All agreed that for a woman to live with a man she was not married to was not neglect, but consensus ended there. One worker even responded, "I don't think that's a fair question!"⁶

This question is not only fair but vital. Unanswered it gives validity to the charge that "social casework is not really scientific at all in the sense that it makes a relentless unbiased examination of the facts," but rather "rests on an *a priori* system of values."⁷ Without clear criteria, a wilderness of unarticulated values may swiftly involve the State in a family's life for novel reasons. Determining what the criteria should be requires answering the following question: For the promotion of what values should the State intervene in family life?

Any number of factors may be relevant in determining what a child's well-being requires. For example, when a child comes to the attention of the protective agency, should the agency intervene because the child's religious training is neglected, as has sometimes been done,^{8,9} or because his parents strongly advocate communism, as has also been done,¹⁰ or because a racial intermarriage disturbs the family's relationship to the community, as was alleged in a case in Connecticut.¹¹

Once the agency decides to intervene, what goals

should be set? Should the child be removed to family of greater wealth or social status or with more acceptable political beliefs? Or, if the child is not removed from his home, should the family be reorganized to strengthen religion or education, or to promote the child's physical well-being, or to make him respect his parents, or to promote family love or all of these?

What is needed are clear standards and an administrative procedure designed to expose the criteria actually applied in any case to close legal and social scrutiny.

Primary goals

The basic goal of a neglect law is to prevent physical, social, physical, and psychological deterioration of children. But there is no guarantee that social agencies will not intervene on grounds irrelevant to this standard, as some courts have done. For example, in one case an agency petitioned for removal of a child because his mother visited taverns,¹² and in another a family lost 5 of their children through adoption while they were petitioning for a reversal of a decision denying the children return to them because their home was too small. A protective statute should require that the child's physical and mental health be the State's sole interest. Agency discretion would then be limited and review channeled into an inquiry concerning child's physical and mental health to the exclusion of other factors.

Even if this is done, the basic issue that still must be faced is what degree of family deterioration should exist before parents are subject to intervention. Is the State to intervene because of a perceived sign of social disorganization, or must it wait until a specified level of disorganization has been reached?

In view of the etiology of neglect and the difficulty of reversing established behavior patterns, some people argue that if the State is justified in intervening at all it ought to do so early. In view of the probability of unpleasantness of intervention to the family concerned, and of the uncertainty of psychiatric knowledge, others argue that intervention should only be authorized when objective and severe neglect is evident.

The American Humane Association's model act for protective services is based on the first view. It would authorize protective intervention "in behalf of children whose health or welfare is impaired

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under immediate threat of impairment as a result of isolation"¹⁴ of law. Such authority, if keyed to be already vague definitions of most neglect laws, could be broad indeed.

However, there are several reasons for basing a statute providing for protective services on the second view:

1. An offer of services may be regarded as a form of punishment by parents, and punishment of any type should not be imposed unless there is prohibited conduct in relation to children. Moreover, since the family relationship is the most intimate type of human experience, interference with it should be permitted only on grounds of actual trouble and not on estimates of future harm.

2. The uncertain nature of psychiatric knowledge along with the lack of professional training of many protective workers raises the probability of harm occurring through premature action.

3. Since the vagueness of meaning given to the word "neglect" permits State intervention in practically unlimited and unknowable measure, the advisability of giving the State more rather than less power to intervene may be questioned.

4. Most important, though defined in terms of health, legal neglect is not a question of medical or even a psychiatric judgment, but is essentially a policy issue. Primarily it denotes conduct in conflict with the child-rearing standards in the dominant culture. If the child is in danger, the policy question is not how dangerous the conduct is for the child, but what degree of danger to a child society can tolerate. Granted that social workers have an expertise that enables them to assess the danger in particular circumstances, that fact does not qualify them to fulfill the social role of judging when the State ought to intervene. That decision ought to be made by courts, guided by the legislature, using the social diagnosis as a source of evidence.

Emotional and social neglect

Neglect has long been thought of by legislators exclusively in physical terms. Actually, if a child lives in a proper psychological milieu, he can tolerate some physical deprivation. Standards are available to determine when malnutrition or disease endangers a child's health or when lack of clothing, shelter, or adequate supervision endangers life or health. Ac-

cordingly, minimum physical standards of care can be set by statute without great difficulty and deviation from them judged objectively.

Statutory protection of a child's psychological welfare is more difficult, but equally necessary. The healthy emotional development of a child is as essential to his ability to live in a society as a healthy physical development. Some social workers and psychiatrists have, in fact, argued that judicial decisions and laws which do not recognize emotional neglect, or other forms of mental damage, are archaic. Others believe, on the other hand, that more needs to be known about the causes and treatment of emotional disturbance in children before "emotional neglect" can be made the basis of neglect jurisdiction. Erik Erikson, for example, has pointed out:

The psychoanalyst knows relatively more about the dynamics and cure of the disturbances which he treats daily than about the prevention of such disturbances. . . . Strictly speaking, we cannot even be sure that we know what causes neurotic suffering until we have an idea of the nature of real health.¹⁵

Thus, the need for action in behalf of emotionally disturbed children is difficult to translate into legal standards because the medical guidelines themselves are uncertain.

Action in this respect on the part of a protective agency is no less fraught with psychic danger to the child than court action, even though under protective services a child remains in his home, while court action may lead to removal. The caseworker's attempt to establish rules could destroy parental ability to control any area of the child's behavior. The mere presence of the worker, representing a new authority in the home, could result in the parent's giving up the vestiges of his own authority or the child's attempting to manipulate one authority against the other. On the other hand, of course, the caseworker could provide the support necessary for the parent to control and guide his child.

Nevertheless, since psychological welfare is so important to the child, since a caseworker may intervene in instances of physical neglect but "treat" for emotional neglect, and since most juvenile courts recognize emotional neglect *de facto*, it would be a wise policy for the legislature to legitimize the situation and at the same time exert control. As it is, protective agencies sometimes treat families for emotional neglect without statutory authority but refrain from taking such cases to court even though the situation fails to improve.¹⁶

In spite of gaps in current knowledge, psycho-



These children may just be dirty and tired like any children who have been out to play, but if they have been locked out and no adult is on the premises, the community may have cause for concern about their protection. So intricate questions involved in protecting children from neglect without violating their parents' legal rights are discussed in the accompanying article.

analysts do know a great deal about the essential conditions for healthy emotional and mental growth. They have found an affectionate relationship between mother (or mother substitute) and the child to be most essential, and continuity in this relationship next in importance. If these factors are absent, they point out, it may be impossible for a child to develop a stable, integrated personality.¹⁷⁻¹⁹

Therefore, legislation designed to protect a child's psychological development might designate the denial of a continuous affectionate relationship as a criterion for intervention in family life, as does the Idaho statute.²⁰ But unlike that statute, it should not permit intervention based on ideas of normality. Intervention should be restricted to cases where the child's intellectual development or the development of his capacities is seriously retarded. This would not only protect the rights of parents to rear their own children, but would also protect children from actions based on unproved theories. The risk of harm through intervention on the basis of little understood factors should not be tolerated.

If such standards are accepted, the interchange between social workers and lawyers may in time lead to the definition of those emotional factors which are so essential to the growth and development of children that their absence justifies State intervention. The object is to have the right questions asked in court; the hope is that correct answers may evolve.

Society has an interest in protecting itself as well as the child. Therefore, if the child engages in serious antisocial behavior, State intervention in his family life, where the roots of such behavior will probably be found, is justifiable. But the legislation

authorizing such interference should clearly indicate that it is the child's behavior and not his parents' that is at issue. For example, if a parent openly engages in immoral sexual relationships, or the use of narcotics or excessive use of alcohol, there is a real risk that these habits may be instilled in the child. If the parent is discreet about such behavior as far as his child is concerned, the behavior may not adversely affect the child's socialization. In the latter case, intervention in the family life would be a punitive attempt to reorganize parental behavior for its own sake and would not be legitimately connected with the goal of advancing the child's welfare.^{21, 22} Therefore, a protective statute should exclude the right to intervene in family life because of the parent's behavior unless there is some direct evidence that it is adversely affecting the child.

Due process of law

The United States Constitution forbids depriving a person of liberty without due process of law. If the Supreme Court of the United States has held that "liberty" includes the right of a citizen to be free "to marry, establish a home, and bring up children," and has held privacy to be constitutionally protected,^{23, 24} There can be little doubt that protective services may be a deprivation of liberty.

The power [of the social worker] to be there bears a terrible weight upon the parents . . . he must take from parents what every man cherishes most of all, his right to privacy within his own walls. . . . Even the actual removal of the child may not be so hard to bear as an alien presence in the home.²⁵

True, many parents will genuinely welcome the intervention of a social worker. Their family situation may have deteriorated into such a morass of hopelessness, or their child's behavior may have become so perplexing, that State initiative in offering help may coincide with their own vague intentions to seek it. In such cases, the requirement of due process of law is satisfied by the parents' acquiescence. But in other cases the services will be resented and even feared and the parents, if they consent at all, may do so only out of fear. Clearly, then, due process guarantees must be met.

Where a person's liberty is involved, the general proposition is that procedural due process requires a hearing in which some tribunal passes on the State's right to intervene. Most protective statutes do not provide for hearings. They either ignore the requirement or they rely on the friction that families even protective services always accept them reluctantly.

True, a parent confronted by a protective worker can obtain a hearing simply by vigorously refusing to accept the services and awaiting the agency's determination to file a neglect petition in the juvenile court. But most parents who are confronted with an offer of protective services may be uncertain of their legal position and may acquiesce only because advice from a social worker seems less threatening than court action. Moreover, many such parents may be recipients of public assistance and may believe that refusing the worker's offer of service may jeopardize their means of sustenance.

In search and seizure cases, even such implicit restraints may amount to coercion sufficient to violate a person's constitutional rights under the fourth amendment.²⁶ Perhaps protective services do not move into the category of constitutionally protected liberties. But they are a searching into the minds and behavior of parents with the threat of removal of their children looming in the background. To work with a man's mind should require at least the same safeguards as a search for his chattels.

The best way to meet this obligation is to require a hearing within 60 to 90 days after services are offered the family on a voluntary basis under statutory authorization. If the hearing were required before any offer of services, the program would be incontestable from the present protective supervision used by the juvenile court, and would introduce the element of coercion so apt to produce hostility in parents. Allowing for the voluntary acceptance of the offer of services could promote the social worker's

chances of developing the kind of helping relationship which can displace hostility with genuine cooperation. And, if the services prove officious, the court could readily terminate them.

The issue at this hearing—unless either protective worker or parent determined that a formal adjudication of neglect should be made—should be limited to the question of whether or not protective services were being administered within the definitions of neglect contained in the protective act and thus may continue. This procedure would not require the judge to become an administrator of the child protective agency. It would give the courts a function especially suited to them: judging whether the State is legitimately intervening in family life to advance the social welfare.

The right to counsel

The final question raised by due process requirements is whether a family should have a right to counsel at the hearing. Since juvenile court hearings need not provide a defendant with the safeguards required in criminal proceedings, counsel is, perhaps, not mandatory. But the absence of procedural safeguards in juvenile courts is not universally applauded. A benevolent deprivation is just as real as a malevolent one.

Edith Varon has aptly illustrated this fact. In commenting on the reaction of some mothers to a letter from the Massachusetts Society for the Prevention of Cruelty to Children initiating contact, she writes:

For those who did not know that a complaint was about to be made, the letter was a shock producing agitation and anger. The thought was, as they put it to me, "Who would do such a mean thing?" . . . Mrs. Fossa was so mad she didn't know what to do, and on advice of her neighbors she took the letter to the police.²⁷

Nor was this a transitory reaction. For many, this anger and anxiety "was still churning within them 2 or 3 years later." And if court action ultimately resulted, the feeling was even more bitter.

Of course, providing protective services does not inevitably engender such anger in clients. Much depends on the quality of the worker. One woman interviewed in another study remarked:

One thing I definitely like about my worker is that she's always pleasant and cheerful. She's the only person or human being I see all week except my howling, snarling kids and they're always fighting . . . but the minute she comes . . . she makes you feel glad that she's actually there.²⁸

The fact cannot be overlooked that in some parents hostility is aroused by anything which would alter the family pathology on which their own morbid sense of well-being depends. The rights of parents cannot be used to shield parents from their responsibilities to provide appropriate care for their children. But this is no reason to conclude that the court should be invoked "only as a diagnostically dictated step in the treatment process of a specific case,"²⁸ thereby relegating due process to limbo.

The best way to assure both that due process of law is observed and that the values on which decisions are made are clearly stated is by providing parents with counsel if they cannot do so themselves, as New York does. Lawyers could help force those persons concerned with child neglect to grapple with the basic social and legal questions involved. Thus, a protective statute should make provision for counsel at the time of the court review, if requested, and clients should be informed of this right on the initial contact.

In summary, legal procedures are not impediments to swift correction of social ills. Observance of legal rights would help to ensure that protective decisions are based on the reasoned application of relevant criteria. This is more likely to protect children than striking at neglect with unknown values and uncertain policy.

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⁹ *Hunter v. Powers*, 135 N.Y.S. 2d 371 (1954).

¹⁰ *In re Dublin*, 112 N.Y.S. 2d 267 (1952).

¹¹ *Murphy v. Murphy*, 143 Conn. 600, 124, A2d 891 (1956).

¹² *State v. Greer*, Mo. App. 311 S.W. 2d 49 (1958).

¹³ *Savery v. Eddy*, 242 Iowa 822, 45 N.W. 2d (1951).

¹⁴ The American Humane Association, Children's Division: Report national agencies workshop on protective services, part 2: Suggest language for legislation on child protective services. Denver, Co 1957.

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²¹ *In re Knight*, 212 La. 352, 31 So. 2d 825 (1947).

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²³ *Meyer v. Nebraska*, 262 U.S. 390, 399 (1922).

²⁴ *Rigsbold v. State of Connecticut*, 381 U.S. 479 (1965).

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²⁶ *Lynnm v. Illinois*, 372 U.S. 528, 534 (1963).

²⁷ Overton, Alice: Client's observations of social work. St. Paul Family Centered Project, Greater St. Paul Community Chest and Councils, Inc., St. Paul, Minn. 1959.

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Too often legislators . . . have operated under the theory that when you remove the people from the welfare rolls you remove their problems as well.

Edgar May, in "The Wasted Americans," *Harper & Row, New York*, 1964.

psychiatrist suggests some points to be considered in . . .

HELPING PEOPLE WHO CANNOT MANAGE THEIR LIVES

IRVING KAUFMAN, M.D.

When Sigmund Freud first began to treat neurotic patients, he was surprised to find that despite all their verbalized wishes for help they came late for appointments, were irritable, complained that the therapy was taking away something valuable such as their creativity, and in general made it very difficult for treatment to proceed. Seeking the reasons for this resistance to treatment, he found that the patient's pathology was serving important functions in his psychodynamic balance, and that, therefore, in alleviating symptoms the therapist had to take into consideration what he was doing to the person in the process. This discovery led to the focus on ego psychology in contrast to an earlier focus on symptom relief.

For a long time, Freud and the early psychoanalysts felt that there were only certain types of people who could be treated successfully. These were the people who had enough motivation for change and a strong enough ego to tolerate the anxiety that the treatment aroused and to face their conflicts. Orthodox psychoanalysis is still primarily geared to this type of patient.

However, if these were the only people offered

treatment, the vast majority of people who need help with their emotional problems would be deprived of it. Actually, the classic psychoneurotic client makes up a relatively small proportion of any psychotherapist's caseload, whether in a social agency or in a private psychoanalytic practice. An increasing proportion of people referred for help are people having difficulty in the management of their lives. For such persons, the traditional psychoanalytic techniques and methods have proved to be highly inappropriate. Therefore, psychotherapists have been trying to work out other more effective methods of treatment.

The core issue has to do with the diagnosis. Ideally, scientific diagnosis requires identifying the etiological agent which produces a specific kind of pathology, runs a definable course, and responds to a specific kind of treatment. To some extent some etiological factors in emotional disturbances can be identified, but for the most part they cannot. This is because an etiological factor in emotional disturbance is much more complicated than the virus, bacteria, or tumor at the base of a physical illness. In the "unmotivated," "hard-to-reach" families and individuals which comprise a protective service caseload, for example, a multitude of different etiological factors appear to be involved, even in persons with similar types of pathology.

The classic psychoneurotic patients, corresponding to those described by Freud, are functioning at a developmental level having certain specific character-

based on a paper presented at a 1965 Institute on Education in Social Work With Unmotivated Clients, held at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, supported in part by the Children's Bureau.

istics. They are able to use language as a major means of communication. Both the client and the therapist expect a logical connection between the thought and behavior. But persons whose personalities are fixated at more primitive stages of development have less capacity to communicate their thoughts and feelings through words. To a large extent they use behavior as their means of communication.

There are only four possible ways any person can express himself: (1) Through words; (2) through affect; (3) through behavior; and (4) through bodily reactions. The clients seen in social agencies such as a protective agency may use all four of these ways of communicating to some extent. However, many of them use behavior as the dominant mode of expressing their problems, and, in turn, require behavioral response from those who would help them deal with their problems. Instead of developing symbolic symptoms, such as an arm paralysis, or loss of speech, a phobia, or an obsession, such people express their problems by beating up their children, deserting their husband or wife, drinking to excess, walking out on their jobs, or in other forms of behavior which get them into difficulty with society. The children play truant from school; they steal; the girls become pregnant; the parents neglect their children.

Because behavior results in social difficulties, however, does not mean that it is based exclusively on social deprivation. Psychological and social factors are usually intertwined in the etiology of such behavior. Direct manipulation of the social environment is as ineffective in treatment as direct manipulation of psychological symptoms. Hypnotizing a person and curing a conversion reaction may relieve a physical symptom, but in some instances may produce more serious symptoms. Similarly, taking a person from a slum and putting him into a "better" but unfamiliar neighborhood may not cure his social and psychological difficulties. An intermediate step is usually necessary to help people with behavior problems benefit from social improvements.

Difficulties in intervention

This intermediate step is motivation. Most people who work in the mental health fields come from middle class backgrounds. They are used to dealing with a client in terms of their own self-image—as someone who can be dealt with in a rational way. But in many social agencies, particularly protective

agencies, they find clients who have come for treatment under external stress, or who have been forced into it by a complaint from a neighbor or by an order from a court. Even enough motivation to seek help therefore, does not exist.

Intervention by a psychiatrist, social worker, psychologist in an attempt to help such people overcome their problems can mean something very different to these people from what it *must* mean if it is to be therapeutically effective. The prospect of verbal interaction threatens to interfere with the habitual mode of functioning and so may arouse great deal of anxiety. Even though their overt disturbance may be a cry for help, they may see the person who comes with an offer of help as someone who threatens to take away their familiar way of relieving anxiety.

What does one do to get help to such people?

Reaching the client is relatively easy when he comes to the therapist of his own volition, saying I have a problem . . . I want help to overcome it. Such a client comes regularly for appointments, and even though he may show resistance he works on his problems. It is quite another thing when the therapist, usually a social caseworker, must go to interview a client who has not sought his help and who acts as though the therapist were a nuisance or a pest. The treatment problem often becomes even more complicated because of the therapist's own counter-reaction to the negative reaction of the client. In addition, the therapist may feel uncomfortable about imposing his ideas and values on an unwilling client unless the client is obviously psychotic and dangerous to himself and others, or is severely abusive to his children.

Not many people would say that a parent has a right to break a child's bones or fail to feed him. However, in many neglect cases the issues are not clear cut, and the caseworker may wonder whether it is imposing something that is not appropriate whether he is acting out of his own, rather than the client's, needs. These are fair and appropriate questions which a therapist should always ask himself. Nevertheless, the caseworker in a protective agency has a responsibility to determine whether the client is dangerous to himself or to his children—whether intervention is necessary to prevent serious family pathology.

Being rejected by the client may be hard for the caseworker to take because of his own emotional investment in his work. A resultant feeling of discouragement may make it difficult for him to per-

and deal with the core problems of the client. partly because of his own discouragement, the caseworker may come to believe that the client does not want to change—in other words, is “unmotivated.” When the caseworker is called at all hours of the day and night because of emergencies in the same family—the husband is drunk, the daughter pregnant, the son picked up by the police—he might wonder when it will end, or whether it will ever end, and how he will ever do anything for the family. This is particularly true if the agency environment implies: “These are unmotivated people, get rid of them. We have to save our time for people who wish help.” On the other hand, an agency environment which gives the caseworker emotional support and recognition for his efforts in dealing with such very difficult people can help lessen the caseworker's feeling of discouragement and make a tremendous difference in his capacity to cope with the problems they present.

Personality structures

What is the psychic structure of the people who express their emotional problems by unacceptable behavior? Many of them are ambulatory psychotics and even more are persons with impulse-ridden character disorders.

It is easy to make a diagnosis of schizophrenia in a hospitalized client who has hallucinations and is deluded, delirious, and assaultive. However, it is not so easy to diagnose the condition of the disturbed persons with less overt symptoms who are so often seen in social agencies. Anna Freud has pointed out that the ego is a dynamic structure which organizes various defenses depending on the stress it is undergoing.¹ These can be defenses against defenses. Moreover, the same person can at one time exhibit a neurotic pattern of defense and at another time a borderline psychotic pattern. Such persons might be called “borderline psychotics.” They include:

1. **The schizophrenic group.** Classical schizophrenic patterns are isolation, withdrawal, regression, and the use of primary process thinking. Such persons tend to view others as threatening objects, the extreme response being kill or be killed, eat or be eaten, destroy or be destroyed.

If the therapist has a patient who says he is hearing a voice telling him to kill, diagnosis presents no problem. However, a client of a protective agency who views a 3-month-old baby as a horrible monster to be destroyed him, although equally psychotic, pre-

sents a different diagnostic picture. He may pick the baby up and throw it on the floor and jump on it and kick it, but the next day when brought into court, give a rational story about having lost his temper. Often such a person can hold a job or keep a house clean.

A review of many cases of child abuse has indicated that many abusive parents exhibit an episodic type of psychosis, characterized in extreme cases by wild outbursts of rage.² The persons who gave vent to such outbursts had exhibited many positive capacities—for example, they could handle money, hold a job, or manage a household effectively. However, many of them were quite isolated in the community and their relationships with others showed many similarities to those of classical schizophrenics. The episodic form of their psychosis complicates the diagnosis and treatment of such people, especially because many of them at times can be quite gentle and even affectionate with their children.

Persons of this schizophrenic type are also often seen by caseworkers of suburban family service agencies. Many people in this group are highly educated and function well as scientists, professors, university teachers, or in other respected occupations. Yet in other aspects of their life their behavior differs little from that of the borderline psychotics seen in protective settings.

For example, a family service social worker calling at a home found a husband and wife rolling around on the floor biting, kicking, and scratching each other in front of their children. These people, however, were not directly abusive to their children.

In another case, a woman told a social worker in private practice that her husband had grabbed her in front of her children, slammed her against the wall, and threatened her with a knife, saying he was going to skin her alive and tear out her eyes. He had then dragged her across the room and pummeled her, screaming and raving as he did so. This man was a very successful person in his profession and the wife was a very good housekeeper who functioned effectively in many ways.

Before such borderline psychotic clients can be effectively treated, a diagnosis must be reached. The terminology used is less significant than a determination of the level of personality development, the organization of the defense structure, and the capacity for regression.

2. **Character disorders.** Persons with impulse-ridden character disorders come to the attention of

social agencies even more frequently than persons with episodic schizophrenia. Their personalities are fixated at a level between the more deeply regressed psychotic personalities and the neurotic personalities. Such persons account for the bulk of the caseload in a protective agency—most of the neglect cases. The abuse cases occur less frequently and are more likely to involve psychotic personalities. Persons with character disorders also account for the bulk of court and prison caseloads. Such people have major problems in managing the realities of their lives. For example, they may live in a "cold water flat" with a pastel refrigerator bought on credit, without having paid for the electricity to keep it going. They tend to be especially inconsistent in their child-rearing practices.

Persons of this type usually have received inconsistent treatment in their own lives. Usually they have had just enough care and attention to know that something is missing; but for the most part have lived in an atmosphere of deprivation, especially of consistent affectionate relationships and models for identification. Such deprivation and inconsistency have impaired their ego development and fixated their personalities at an infantile stage of development. They behave much like 2- to 3-year-old nursery school children. Many of them have the charm of such children, but they also demonstrate other childish characteristics. For example, their relationships are transient and fleeting. They can engage in some kinds of group activities, but they are likely to go off in some parallel, lone activity while with a group. They tend to use various kinds of projective mechanisms to cope with their problems and to resort to isolation and to repeated compulsive actions when under stress.

Such persons also tend to postpone dealing with problems directly. It is extremely difficult to get them to carry out a responsibility, however minor, such as going downtown and paying a bill, even if they have been given the money to do so. They may complain about a toothache, be given a dental appointment, and then come up with a reason for not keeping it. They have an enormous amount of difficulty in facing anything involving any stress and tend to use isolation and denial as a way of handling even the simplest daily problems.

Such people also have difficulty in handling their aggressive and sexual impulses.

In normal child development, the child progresses from the direct expression of his instinctual impulses to a gradual neutralization of them through his rela-

tionship with the important people in his environment. He then develops an increasing capacity for ego mastery. Persons with an impulse-ridden character disorder have not had the ego-building experience which will enable them to gain gratification or mastery of their environment. Their resultant tendency to discharge their instinctual tension through aggressive outbursts or promiscuous sexual behavior creates a multiplicity of problems for themselves and others.

Not only do they come into conflict with the community, but also, because they have not acquired the ability to sublimate, they do poorly in areas requiring this ability. As children, they have difficulty in learning and in social adaptation to school, and as they grow older they have difficulty in job adaptation, money management, home care, and care of the children.

Results of pathology

The question can pertinently be asked whether there are some kinds of pathology that make for success in our society and some kinds that make for failure. A certain type of paranoid personality, for example, can be observed in some very shrewd businessmen. A man of this type can outwit everybody and does not care if he harms someone else. He goes his own way, accumulates money, power, college degrees, and honors. His particular type of pathology is quite compatible with success as it is defined in large segments of our society.

In contrast, there is the kind of person who cannot sit still in a classroom and cannot concentrate on school work. He trips or punches anyone who wobbles by. He does not get to school, or to his job, on time. If he has any money, it runs through his fingers. This type of person does not learn in school or achieve success in our culture. Although there are many people of this type in all socioeconomic groups, there is a tendency for such persons to regress to or remain at a low socioeconomic level, regardless of the level at which they start out.

Implications for treatment

What kind of therapy can be effective with persons whose emotional development has become fixated at an infantile level?

Conversation has much less meaning for persons thus emotionally retarded than for people who have achieved higher developmental levels. Therefore,

they need a caseworker who can communicate with them in other ways.

Anna Freud,³ Melanie Klein,⁴ and other pioneers in child psychiatry have noted the importance of developing a method of communicating with the child needing treatment. Obviously it is not possible to put a child on a couch and say, "Speak of whatever comes to your mind." The first thing the child would say would be, "What can I do next?" Probably his first thought would be, "How do I get out of here?"

This is also true of adults who are not used to discussing problems of any type with anyone. In some work with children from socially, economically, and psychologically deprived backgrounds who have done poorly in school, it has been found that the children did not know how to communicate their wants or thoughts. The experience of being taken in an adult's lap and being talked to affectionately was an entirely new one for them.⁵ Obviously, a psychiatrist or social caseworker cannot put an adult in his lap and give him the child-rearing experience he has missed. However, treatment for an emotionally deprived adult has to be a restitutive process before it can be anything else. It has to supply some of the object relationships and other nurturing and ego-building experiences that have been missing in his life.

The first step is to help such a person build up a recognition of the relationship between cause and effect, the effects on day-to-day living of thinking ahead and planning. For this reason, much of the necessary treatment of families in neglect cases may seem to be at superficial levels.

For example, a mother appears unable to realize that in order to provide breakfast for a child it is necessary to have some milk or cereal in the house—not because she does not have the intelligence to know this, but because her own infantile needs are preventing her from thinking of the needs of the child. The restitutive process involves giving her an experience with someone who goes through the thinking and planning with her as an ego-building process. Trying to deal with her unresolved hostility to her parents or other conflicts may have a place at a later stage in treatment, but not until she has been shown by example ways of dealing with her everyday problems.

Similarly, the person who cannot face going downtown or who cannot keep a dental appointment needs the corrective experience of having a relationship with someone—a caseworker, for example—who not

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only says, "Here's the money to pay the gas bill," but who also goes along with him on his visit to the dentist.

There are several reasons for recommending this treatment procedure. Verbal communication has relatively little meaning for such persons. They do not have enough ego to face the stress of doing even those things which are to their advantage. They need the experience of having someone at hand who not only cares enough to be concerned about their problems, but who also helps them face and carry through on their responsibilities for doing something about them. In playing this role, the caseworker can help such a person build up a model of behavior different from his accustomed pattern of fright and avoidance.

There also needs to be restitution of a parent-child experience for such a person at a level which he can understand. The caseworker does not play games with his adult clients, but the process of going to see them and having a cup of coffee with them, giving them material things, or just being present and interested, as in going with them to the doctor, provides this kind of restitution.

Unfortunately this type of casework approach to the client has less prestige in the social work profession than the psychoanalytic, interpretive, confrontation sort of procedure. Nevertheless, the therapist must deal with the client at the point where he is. One does not start interpreting personality dynamics and confronting a person with his psychological shortcomings if he cannot plan how to get breakfast for his child or get his clothes ready.

The question often arises: Can this type of planning be called treatment? Of course it can. It is treatment based on a diagnosis of the client's level of development. It is treatment based on what the client needs in the way of ego building. It is exactly appropriate. Although a different type of treatment may be called for as the client progresses, the approach needs to be geared at all times to his level of

fixation, the structure of his defenses, and the way he reacts to others.

The agencies

Social agencies deal with many people whose life experiences have been marked by inconsistency, desertion, a feeling that no one cares. Such people often act in ways which antagonize the community. As a result, the development of the social agency structure in most communities has been in response to each of the protrusions of a huge iceberg. As a result, there is a tendency for the various parts of these problems to be dealt with in discordant ways.

While efforts are constantly made to coordinate programs, more needs to be done to give the families served some consistency in approach and in philosophy. For example, one agency may be working with a boy who is in court for stealing; another, with his sister, an unwed mother seeking placement of her baby; and another, with the parents in an effort to help them provide a better home life. All of the agencies may be doing excellent jobs, but such a multiple-agency approach is in effect repeating the same kind of inconsistency which people who have so many problems have experienced all their lives. When people have never had any consistent parental care in their own childhoods—have perhaps been shifted from foster home to foster home—the experience of having a profusion or succession of counselors or authority figures intervening in their family life may merely accentuate their feeling of not being able to count on a continuing relationship with one person who cares what happens to them.

In addition, there is the problem of dealing with the community's antagonism to such people. Because people who are emotionally retarded often do things other members of the community do not like, persons who work with them tend to get discouraged. Some public agency policies seem to reflect a desire to get rid of as many such people as possible by giving them a one-way ticket to another State, or by putting those who behave in antisocial ways in institutions in isolated rural areas where they will not disrupt the community.

However, the objective of treatment is to help emotionally retarded people become members of the community and to develop an ability to care about other

people. This cannot be achieved by policies which are an expression of hostility and which serve to isolate such people from the community even more than they already are.

The problem of dealing with people who act out their emotional problems is not limited to social agencies which see people from the lower socioeconomic groups. Therapists in private practice see many people from middle and upper class families who behave in a similar fashion. Their children behave very much like the children seen by a youth service board, a family service agency, or a protective service agency. They have the same kinds of learning disabilities, they cannot concentrate on school work or sit still in the classroom, and they make nuisances of themselves. Some of them use drugs and some of the girls get pregnant.

Therapy is as difficult with these children and their families as with children from lower socioeconomic groups. Their attitude toward authority is equally hostile. They are brought to the therapist's attention chiefly because they are not doing well in school and their parents are worried that they will not go into a good college. But the parents show the same unconscious drive to perpetuate the children's pathology as do the parents of lower socioeconomic status whose children are in trouble. For example, they do not ask their children appropriate questions. If a boy comes home with a wagon that does not belong to him, they do not ask him where he got it.

No matter what socioeconomic group an "untreated" client comes from, therapy to be effective must be based on the following considerations: (1) diagnosis in terms of personality level; (2) what this implies in regard to the treatment approach; (3) how he is likely to interact with others; and what kinds of direct and indirect social objectives are involved in treating him.

¹ Freud, Anna: The ego and the mechanisms of defense. International Universities Press, New York. 1946. (Written in 1936.)

² Kaufman, Irving: Psychiatric implications of physical abuse of children. In *Protecting the battered child*. Children's Division, The American Humane Association, Denver, Colo. 1962.

³ Freud, Anna: The psycho-analytical treatment of children. In *Publishing Co., Ltd.* London. 1946.

⁴ Klein, Melanie: The psycho-analysis of children. Hogarth Press, London. 1949.

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analyses of studies of social class
subcultures provoke comments on . . .

SOME DIFFERENCES BETWEEN PEOPLE AND STATISTICS

CATHERINE S. CHILMAN

● Investigations by social scientists into the causes and characteristics of poverty have mushroomed in recent years. Social research has moved out of once impoverished, academic closets into a new alluence of prestige and increasing methodological competence. It occupies a front-row seat in the arena of community action. Social researchers are investigating many important problems, including those related to social class structure and patterns of living. Their studies are throwing increasing light on some important questions concerning, among other things, the causes and effects of poverty.

Administrators and practitioners who seek to help the poor are eager to get as much enlightenment as they can from the researchers. And most researchers are eager to provide it. However, scientific investigation has many limitations which prevent quick, general "breakthroughs" in knowledge that can be readily applied in action programs. While the conscientious social scientist presents his findings with a multitude of warnings as to their limitations, these warnings tend to get lost or disguised in the translation of research findings into a readable, understandable form for action-oriented consumers.

Research findings must, of course, be translated for a wider audience so that they can be put to use, but precautions are necessary. Some of the most important precautions for those who would apply studies of social class in dealing with people in need of services will be presented in this article. Although it is focused on research about the cultural patterns of the very poor, most of the precautions are also in order in applying the findings of other bodies of social research.

Although further research may reveal that certain characteristic life patterns are found in the culture of the poor in all Western societies, it seems premature to embrace this contention too ardently. Studies in this area are relatively few, the samples studied have been small and not necessarily representative of the larger population, and methods of study have tended to be observational and intuitive and subject to the biases and perceptions of the interviewers. Greater scientific precision is being developed in this area of research, as well as in others, but the time has not yet come when great confidence can be placed in results.

It would probably be more accurate to talk about the *subcultures* of poverty. The prefix "sub" is used because most of our poor would seem to subscribe to the "middle-class American way" as a cultural ideal,

sed on the introductory chapters to a forthcoming volume
Dr. Chilman, "Growing Up Poor," an analysis of the child-
ring and family life patterns of the very poor, to be pub-
hed by the Welfare Administration in June 1966.

at least, which they accept, in theory and fantasy. Hyman Rodman,¹ for instance talks about the "middle-class value stretch." By this he means that the poor, caught in a situation of economic deprivation and social disorganization, stretch and adapt the values of the middle class to the realities of their own lives. Myers and Roberts² are among those who discuss the necessity for the poor to have a pragmatic, materialistic, present-oriented attitude, pointing out that when getting and holding a job and buying food are paramount necessities of the moment, many middle-class values, such as a consideration of the subtleties of human relationships, are necessarily pushed to the background.

Subcultures of the poor

The term "subcultures" seems more appropriate than "subculture." This is because research on other aspects of varying cultures, as well as common observation in working with low-income people from various backgrounds, would strongly suggest that among those who live in poverty there is a wide variety of differing living patterns, associated with race, religion, region of the country, national background, rural-urban locale, exact social class level, age, and sex. Some recent studies of low-income cultures have examined questions of racial patterns within the same social class;³⁻⁵ some have examined patterns in relation to both masculine and feminine roles;⁶⁻⁷ some have looked at the subcultures of the adolescent poor;⁸⁻¹⁰ and a very few studies have carefully differentiated their population as being either working class (upper lower or middle lower) or lower-lower class.¹¹ On this point, Elizabeth Herzog has commented:

... Reference to the poor does not, of course, mean the lower layer of a three-way breakdown into upper, middle, and lower socioeconomic groups. We have had abundant evidence that this lower segment of the traditional three-way break is itself divided into a number of layers. We have evidence, too, that the life-ways of the very lowest layer differ from the others in this same band more than the so-called upper-lower differs from the lower-middle.¹²

She goes on to say that "... the ill-defined group referred to as 'the poor' does not include the stable, respectable working class [the skilled and semiskilled blue-collar workers]." Since many studies of lower class culture do not make adequate discrimination between this class of steady workers and layers below it, assumptions about the "culture of poverty" may, in

at least some cases, be wrong ones. Moreover, evidence is emerging from studies of recipients in the program of aid to families with dependent children (AFDC) and others of the dependent poor that the important differences between the very poor who manage to maintain themselves without public assistance and those who do not have the resources to achieve even a minimum level of economic independence.^{13, 14} For example, negative public attitudes toward mothers who are dependent on AFDC tend to transfer to the mothers and their children and are associated with a sense of failure, strong self-disparagement, and hopelessness.

Occupation, education, income, and place of residence are the factors most often used by researchers in ascribing a certain socioeconomic level to a person. If the unit of study is the family, however, the factors of education and occupation are considered only in relation to the *head* of the family. Sex is attention paid to these factors as they apply to the wife and mother (unless the father is out of the home), and even more infrequently is the grandparent generation considered. Yet the characteristics of the wife and grandparents may be important, particularly in relation to the ways in which they may affect child-rearing and family living practices.

Thus, since American society is still somewhat fluid in regard to upward (and downward) social mobility, and since men and women sometimes marry outside their own social class, there are variations in the class-determining factors within each social class now described. A more sophisticated view of family social class membership is indicated by consideration of this kind.

The question of within-class layers applies also to studies of culture characteristics of racial groups. When Negro-white differences are examined there is a tendency to make insufficient allowance for the many layers of social class groups and the fact that a much larger proportion of Negroes, than of whites, are at the lower socioeconomic levels. Thus, cultural patterns are often described as being "typically Negro," when, in fact they may be more typically lower class than racial. More careful studies, taking variations in socioeconomic level into detailed consideration, are beginning to shed more light in this area.

Another area in which a careful delineation of subcultures may be necessary is in rural, as contrasted to urban, poverty. Moreover, in considering rurality, differences would probably be found between rural-farm compared to rural-nonfarm cultures,¹⁵ in

ural areas close enough to urban areas to be strongly affected, and in rural areas isolated "back in the hills and hollows." The condition of rural isolation with lack of opportunity for escape may tend to "freeze" subculture with especial rigidity. Then, too, isolated rural areas, with their provincialism, probably carry a stronger regional and historic flavor in their subcultures of poverty"—if the rural areas actually have subcultures. From the little that is known, it appears that the presence or absence of subcultures in rural areas would be strongly affected by the region itself: its history, geography, and economic situation. Few studies have investigated the subcultures of the rural poor, and yet the rural poor make up about 5 percent of our total population and 50 percent of the families have incomes below the "poverty line." An exception is a recently published study of a lower class, white religious group in an isolated mountain community in the South.¹⁶ In a number of ways, the cultural characteristics of this group were different from those commonly reported from other studies of the poor.

Limitations of method

Another limitation to research findings concerning the subcultures of poverty is found in the biases imposed on research in general by the fact that findings are irrevocably and inherently tied to the hypotheses and questions on which the study is based. That is to say, the researcher may miss important facts unless he designs his study with pertinent questions in mind—or unless he observes certain facts in the course of his study and redesigns it so that he can investigate them systematically. For example, the life styles of the very poor may contain significant elements—such as defense mechanisms of humor, drama, and fantasy—that will not be found unless relevant questions about them are built into the research design. If all the relevant questions are not asked, only part of the total picture of low-income cultures—or whatever other subject is under investigation—becomes available. In fact, it seems as if research has focused chiefly on the weaknesses of the poor rather than on their strengths.

There are also difficulties associated with whether or not data obtained with the selected testing instruments are reliable. A full discussion of reliability cannot be presented here. However, it should be pointed out that special difficulties arise in the use of questionnaires with low-income groups. For example, a low level of literacy frequently obtains in

these groups; words and phrases often have different culturally affected meanings from their meanings in other groups; the people questioned tend to respond in the affirmative in order to ingratiate themselves with the researcher; and the testing situation may be far from ideal.¹⁷

Another limitation to some research findings regarding social class differences also involves a difficulty often arising in other research. This is the frequently misunderstood difference between statistical and practical significance. For instance, many of the findings regarding parental practices of low-income families are derived from comparing their practices and attitudes on various behavioral dimensions such as discipline to the practices and attitudes of middle-class families. While a behavior or attitude may be found to be significantly (in the statistical sense) more prevalent in one group than another, that does not necessarily mean that this behavior or attitude is *characteristic of most of the people in the group*. To take a hypothetical example, 10 percent of a sample of middle-class parents may report that they use physical force in disciplining their children, while 30 percent of a sample of parents from a lower socioeconomic class may report this practice. Therefore, statistical analysis may show that significantly more of the parents from the lower class than from the middle class use physical forms of discipline. However, 30 percent is clearly a minority of a reporting group. In the search for interesting research findings, it is a temptation to report differences as if they had greater practical significance than they do.

Another word of warning. Generalizing from findings about groups to assumptions about an individual is unwarranted. For instance, in discussing the subcultures of the poor, Elizabeth Herzog¹² warns against taking a "cookie cutter" approach to an understanding of *individuals* in the various social

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classes. Not only is every person composed of a cluster of identities related to his many reference groups; he also has his own unique psychological style and genetic potential in making use of and expressing his identities. Although this comment on individual differences is old hat to those in the service professions, a "new hat" enthusiasm—such as the impact of cultural differences—can lead to an over-enthusiastic ritual of hat-changing. Many of the old hats, along with new ones, are needed in efforts to understand the complexities of human behavior.

Hazards of predictions

Not only do such conceptual factors militate against the generalization of findings about groups to conclusions or predictions about individuals, but so do some methodological factors. From the methodological point of view, predicting individual behavior from research evidence derived from groups is a very sticky problem. Although a full exploration of this problem cannot be given here, a few general, nontechnical comments are in order.

In the first place, research evidence pertaining to groups tends to be of more value to persons engaged in the development of general policies and overall programs than to those engaged in work with individuals. This is so, mostly because the bulk of research pertains to *group* trends and tendencies and to likenesses and differences between *groups*.

Transferring measures of groups to individuals is methodologically hazardous for many reasons. An important one is that measurements of groups usually involve the use of averages or of proportions such as one-third of a group. Averages and proportions fail to take into account the variability of individuals. An average group score might be 50, but some individuals might have a score of 5 and some of 90.

Some statistical measures used in research readily yield a measurement of this variability—commonly called the variance or standard deviation. When such measures are available, the meaning of evidence as it may apply to individuals becomes clearer. For technical reasons, contingency analysis (chi-square) is the statistical measure commonly used in studies of attitudes, life styles, values, and behavioral practices, partly because with this technique many group averages may be compared simultaneously. This statistical method, however, fails to provide a ready measure of variability, and thus offers few clues to what the research evidence may mean for specific group members.

A hypothetical example will help to clarify this point. A number of studies may show that a large proportion of various kinds of middle-class children from many categories of children from lower class backgrounds get grades of B or higher in school. This is the kind of result that can be derived from the use of a research design which lend itself to contingency analysis. The evidence reveals only general information as to the tendency of these two social class groups to obtain different average school grades.

More specific information can be obtained if the study design and statistical analysis make it possible also to report that groups of middle-class children obtain an average of 2.9 in school grades (when A=3 points, B=2, C=1, D=0), while groups of lower class children obtain an average of 1.7, and that the variability in middle-class groups is 0.4 grade point while the variability in lower-class groups is 1.3 grade points. In this hypothetical example, one of the helpful pieces of information yielded by reporting different amounts of variability in the two groups is that the lower class children are shown to be less like each other in the grades they receive than are middle class children. Therefore, it would be more hazardous to predict a grade-point score of a child from lower class background from a knowledge of school for his group than it would be to predict the grade of a middle-class child.

The example is hypothetical, but some research findings actually *do* suggest that the variability of groups of the very poor may in a number of ways be greater than in middle-class groups.

To sum up, research design which permits a ready computation and presentation of measures of variability also permits more specific interpretation results, especially in their application to individuals. As already noted, much of the research concerning social class patterns tends not to use measurement instruments which readily yield a measure of variability. For the practitioner who is seeking to understand and help individual people, research findings about groups may provide helpful clues but individual diagnosis and treatment approaches are still very much in order.

Sample selection

Passing reference was made earlier in this paper to problems of applying research findings when only small samples of people have been studied. The intricacies of sample selection are far too great to permit a full exploration of this topic here. However,

one point needing emphasis is that the *size* of a sample is generally not so important as the method of choosing a sample.

Studies are far more likely to tell something about a group of people in general if investigations are planned in such a way as to provide for a *random* sample. This means that the persons whom one chooses to study are selected so that they fall into the study group by chance and that all the possible members of the larger population about which information is sought would have an equal chance of being selected.

For example, if one were to do a study of public assistance recipients in a certain community, one would choose the subjects at random from all the people receiving public assistance. If sufficient care were given to defining the study universe (in this instance all the public assistance recipients in the county) and to using an approved method for selecting the random sample, a 2- or 3-percent selection from the total group should, in general, provide an adequate study sample. Then if almost all the members of the sample were reached for the investigation, it should be possible to make general statements about the total public assistance caseload *in the community studied* based on an analysis of the findings from the sample, provided other conditions of sound research were met.

Unfortunately, many studies of social class differences fail to adhere to adequate methods of sample selection. People sometimes become research subjects because they volunteer to be included in a research project, or because they live in a certain neighborhood, or because they answer a mailed questionnaire. In such instances, the results of the study may be interesting, but because the subjects are not likely to be representative of a larger group, it is extremely hazardous to apply the findings beyond the particular group studied. Nevertheless, wider applications are frequently made.

Moreover, even if an investigation has been carried out with an adequate random sample in one community, the findings do not necessarily apply to another community, although such applications are frequently attempted. Allied to this point is another. Studies are time-bound as well as being place-bound. Findings for a certain community in 1960, for example, may not apply well in 1965 and very likely even as well in 1970.

Present efforts to understand the "culture of poverty" derive from the best of intentions. But they may lead to dangerous and degrading stereotyping if

proper care is not taken in designing and interpreting research. By identifying some areas where precaution is needed, however, I do not mean to intimidate those who seek to understand and use research findings. It is as possible to be trapped by oversophistication as by the lack of it. Although research findings surely have their limitations, they can illumine the work of the administrator or practitioner if both proceed with a spirit of open-minded interest or exploratory application. Although "a little knowledge is a dangerous thing," not using that which we have can be even more dangerous. But the use must be guided by wisdom.

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HELPING MEDICAL STUDENTS FIND THE STRENGTH IN PEOPLE

PAULINE G. STITT, M.D.

● A medical student sat, head in hands, lost in thought while he studied the thick hospital record of a teenage girl in an American city. There were the cover sheet, administrative papers, professional histories, "progress notes," laboratory reports, and other entries found in a hospital record, which together usually give a picture of a medical condition, and sometimes, even of a patient.

The student's face was grave.

The preceptor asked the student what was troubling him, and the young man replied, "I can't get over what this record tells, and what this patient shows, and I feel this way over and over again on this home-care service. How in the world do people hold together through these illnesses and terrible life experiences? Why do some people seem to have more strength than others? Are there ways we can help people have strength, or, can we discover what kinds of strength they do have, and then build on them?"

That student, in seeking his patient's reservoir of strength, had touched on one of the most agreeable, interesting, and promising aspects of medical teaching and patient care: The identification of the kinds of strength a patient has, and the deployment of services to reinforce and, if possible, increase that strength. All of his questions were pertinent though at present largely unanswerable. Search for answers to the last two could put new life in medical teaching, and in the practice of the various professions serving people: *Are there ways we can discover the kinds of strength people have, and then build on them?*

The student's questions led to action. He and the preceptor concentrated on strength detection and utilization during the rest of his stay on the service.

Today, enlightened medical care goes beyond treatment of illness and concerns itself, where possible, with prevention. In addition, it is giving increasing

attention to *constructive medicine*, medicine which moves forward into the healthier and more positive areas of fortifying and enhancing existing strength and potential. This threefold concept of medicine—care—treatment, prevention, and constructive service—is applicable to most fields of medical care, is particularly relevant to family medicine and pediatrics, where dynamic care identifies, and then works with, the vast forces of human growth, development, and adaptation.

When you build a bridge you are as much concerned with banks and abutments as you are with the river. In combating illness or injury the same constructive principle applies. Although at some point you may have to remove an offending agent, real restoration and healing, when they occur, come from whatever strength still exists.

All kinds of strength are usable. In pediatric maternity care it is especially rewarding to reach beyond whatever physical strength may exist, and locate and build on all the cultural assets a child, family, and his social group may possess. Furthermore, the child can often be best served through services supplied to his mother or father or his wife and family, rather than through exclusive reliance on what can be done directly for him. Thus, effective pediatric care tends to follow the physiologic mode of reaching an unborn babe best through the umbilical cord, and an infant through the breast.

To help children then, one nurtures not only the children but those who are directly providing them with care. One needs to "help the helpers." The true of professional "helpers," it is true of communities, and smaller social groups, and it is particularly true in working with the hardest pressed "helpers" of all—the parents.

This made it possible for one woman, in thank-

clinic for 2 years' service to her children, to say: Goodbye. The thing I appreciated most is that you folks knew how hard it is to raise children!"

Search for and utilization of what strength the parents have may be particularly rewarding for professional persons working with families who have had to devote strenuous efforts merely to survive. Such people through long experience in coping with problems of survival may have acquired treasuries of potentially accessible strength.

Today's programs for children with cerebral palsy, for example, often use "standing tables" and related devices to enable the children to maintain balance while playing. For ages, little children similarly afflicted have been helped to stand in small wooden barrels, by parents who perceived their children's needs. At first glance, the sight of a child in barrel has sometimes appalled professional workers, but a closer look makes clear that it is the cerebral palsy that is appalling and the barrels represent an interesting and effective cultural improvisation, later improved on by certain professional modifications. There are often similar treasuries of strength found in ethnic groups who have accumulated a shared wisdom in coping with life's problems. In working with such groups, it becomes a professional imperative, and a privilege, to search for the power and the glory that carried them through the past and to today.

Professional students and multidisciplinary teams working with people in low-income areas, especially those of minority ethnic groups, are often warned not to apply their own middle-class-value judgments to their patients or clients. This is important. But far more important is the need for the preceptors to be sensitive and to encourage students to initiate and sustain a systematic search for the strength in the people they serve. This is a straightforward approach to a professional inventory and appraisal of the resources within a situation in which one hopes to be helpful. Perception of strength is especially helpful if it is "fed back" to the patients, back to those who have their own strength and back to others who may profit.

Mrs. Callahan found that her youngsters liked nothing better than an early breakfast of hamburger, fried potatoes, and french fries when their father came in from his night shift. Student health workers eyed the menu squeamishly. Mrs. Callahan explained the importance of this nutritious meal in the company of a beloved father. As she said: "Good food's good anytime of day—and the kids need to be with their old man anytime they can get a chance."

Mrs. Callahan's recognition of the importance of

nourishing not only her children's physical needs but also their good relationship with their father was a lesson with great carry-over value, for the students not only learned from Mrs. Callahan, but Mrs. Callahan herself had the pleasure of seeing that they valued her good sense and remembered and used her ideas later with other families.

In all forms of diagnosis, the view of the patient can vary from observer to observer, each viewer having his own vantage point. This selective perception can provide revelations no single observer could glean. A multiprofessional medical care team may catch glimpses of their patients' rich and varied personal and social resources when each profession is encouraged, or required, to include a presentation of the potential strength seen in the patient and in the situation which surrounds him.

The preceptor's role in preparing students to see the strength in their patients is to see the strength himself. He has to practice constantly to sharpen his own perceptions in this regard and to recognize and encourage such perceptions in his teaching colleagues. Then the teaching team can convey these ideas through example.

Combating cultural shock

Numerous examples could be cited from the writer's experience in teaching medical students in a home medical care service in a large city, where the medical, nursing, and social work professions collaborated in providing home-based medical care to patients living in a crowded, low-income area. A new group of medical students reported to the service each month, and, with instruction and supervision, assumed responsibility for home-based medical care for a number of patients varying widely in age and medical condition.

In addition to the usual adaptation a student has to make on entering any new service in a teaching hospital, these students had to accomplish two other major adjustments. They had to accommodate to the "cultural shock" of sudden acquaintance with modes of life different from their own life experience, and to come up against, and survive, the shocks of their first major encounters with illness in people's homes. Up to that time, the students' experience with illness had been almost entirely with patients safely ensconced in the orderly confines of a teaching hospital, in the midst of impressive equipment and experienced workers.

Disease, disaster, and human suffering are difficult

to meet even in a hospital but can be unnerving when first encountered in a dilapidated hovel where an unkempt, suffering person struggles in misery while frightened members of his family look on in anguish. Even without the illness, the living situation may seem to the student to be more than a human being could endure.

Those in the serving professions must survive too, if they are to be helpful. This is true at any age or stage of professional development. Each professional worker has to be acutely sensitive to his patient's needs and yet stable enough to stand steady for his patient's sake. This is especially important during the early traumatic experience encountered in the professional preparation of future doctors, social workers, and nurses. Nothing must go wrong with the patients—or the students.

Students need challenging experience, but they need mature and understanding help from their instructors, so that what is challenging up to a point does not become overwhelming and permanently damaging. On this home medical service the teaching group found that much support could be supplied through helping the students ferret out the potential strength in every situation.

The medical students found wretched housing and makeshift domestic arrangements confusing and tended to leap to discouraging opinions of people who lived in any degree of squalor. As they reacted to the unfamiliar life-chaos they were encountering, they were apt to be unduly impressed by rigid orderliness, to the point that sometimes they were blinded to other aspects of a home. A distraught, compulsive mother who kept her house "as neat as a pin" (and perhaps without a pin's worth of coziness) often impressed the students as the model mother on the block, but they tended to recoil from occupants of crowded, cluttered, and confusing quarters and thus to overlook whatever strength these people had.

However, the social worker and public health

nurse on the teaching team usually managed little by little to bring to view the warmth, the fortitude, the love, and other healthy elements of family functioning often hidden from the students by domestic chaos in which some families were submerged.

The students especially needed help in understanding patients of ethnic backgrounds other than their own. But with help in detecting the strength in each individual they became emancipated from the stereotypes which otherwise would have hampered their functioning as physicians. Then they were able to sense the strength in people and to harness it in ways that made medical care exciting and effective.

An example

The B.G. family helped open the eyes of a number of students. The family consisted of a pair of elderly Negro grandparents, making a home for several small grandsons on a subsistence income. The exact composition of the grandson-group changed from time to time as the grandparents and the boy father and mother, dividing the responsibilities of child care, would decide which boys needed to be with their father and mother and which might profit more from being at Grandpa's.

Each new group of medical students was apt first to view the B.G. ménage with distaste. Accustomed as these students were to themselves, their friends, and the representations of family life they had seen in movies, magazines, and other glamorized representations of home life in the United States, many of them suffered sharp "cultural shock" when they entered the home of people of different appearances, different household arrangements, and conduct different from what they were used to.

Finding the grandfather, ill with diarrhea, in bed with a young grandson who had a sore throat while Grandma and three other grandsons ate chicken soup 4 feet away at a card table was enough to nauseate one student and make him want to leave the case. Encouraged to hang on and helped to become acquainted with the family through the social worker, the nurse, and the medical preceptor—all of whom kept asking the student at every case conference what strength he saw in the family—the student soon gained his poise. Eventually he became the family champion, and spent much of his own case-report time pointing out the "guts," "backbone," and ingenious approaches to life he was discovering in the family.

The old grandfather had severe heart trouble and

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The pride of her children reflected on this mother's face indicates that the medical team concerned with their health supervision will be able to build on her maternal strength.

his wife's condition was almost equally precarious. Prognosis for each of them was hopeless for recovery, and poor for long survival. Unsure whether the man and wife realized these facts, the succession of medical students who went into this home worried about what the old people's attitude might be if they did grasp the bleak outlook. The grandfather finally showed them the light. One morning after he had had a close call with a severe heart attack, he used the little breath he could muster to tell the students *his* goals.

He said, "I am thankful we made it through last night."

("We"? himself? he and his wife? he and his wife and the service?) The old man made a sweep of his arm as though he meant all.

"I am thankful we made it through," he repeated. These are hard times for boys like ours. Things are going to continue to be hard for a long time ahead. The boys will need a lot of help to hold up and be good men. Their grandma and I know we won't be able to hang on much longer, but we figure that every day we live, we're getting them in better shape for when we have to go!"

The medical students who heard that were no longer blinded by the deceptive appearances of domestic clutter that exist when valiant people maintain homelife for five little boys in a rundown flat. They saw the majesty of the situation and allied themselves with it. The medical care they gave that old couple had scope. It dealt not only with the present heart disease, but with helping two old people hang on long enough to give the young a "good start."

The following sequence of student reaction became something of a pattern on this home-care service: initial cultural shock; beginning recognition of

strength, further stimulated by selective perceptions of the professional preceptors serving the same family; and finally a flowering into a well-balanced observer, alert not only to pathology, but also to the sound, the good, and the healthy aspects of the family's life, on which professional workers could build their therapeutic and nurturing efforts.

At the end of their month's assignment, students left that teaching service and scattered to their next hospital posts. From many of them, and from some of the units on which they subsequently served—especially the psychiatric service—reports drifted back of the carry-over of this constructive learning experience and of the pleasure and usefulness the students continued to find in the identification and utilization of the kinds of strength to be found in patients and their families.

Feeding patterns

Family feeding, particularly infant feeding, provides other examples of the usefulness of strength perception, and of the importance of respect for cultural patterns.

Among all sorts of human groups one finds highly organized behavior and traditional practices connected with child feeding. Any large American city turns out to be a treasure chest of the world's interesting feeding customs, if one starts looking.

Medical students need to be reminded that infant feeding has been going on since time immemorial and that unless elements of wisdom and understanding had been employed, none of us would be here today. They also need to be reminded that over the years as technical knowledge of foods, nutrition, and infant needs has been changing, other changing factors—sanitation, transportation, food preservation, and food processing—have also had a drastic effect on infant feeding patterns.

In past generations and down through the ages, feeding traditions were developed and passed on from one family to another in the interests of keeping the children alive. Because of sanitary improvements and greater availability of safe foods, some of the old patterns have lost their pertinence. Nevertheless, traditional family feeding methods always deserve thoughtful attention. For example, with the present in-migration to the big cities, and the poor housing arrangements which some of the incoming couples find, diarrheal disease is again a real threat. Therefore, it might be well to encourage the practice of prolonged breast feeding, once traditional among

some ethnic groups. One should risk early introduction of solids and wide choice of food for babies only where there is top-notch sanitation. A medical adviser needs to listen carefully to a family's feeding ideas, select those that are nutritionally, pediatrically, and hygienically sound and use them as the foundation for his guidance.

Patients as teachers

According to Hippocrates, the physician is forever beholden to his teachers. It follows that some of us can never hope to repay those who have taught us the most—our patients. This is especially true in pediatrics and in maternity care, those tradition-rooted portions of medicine where the richest source of learning is the enlightenment derived from respectful observation of the varied maternity and child-care methods which have kept mankind alive through the ages. Among the most instructive experiences can be those the physician has in working with people who have been obliged to get their clues for child care directly from their children. Such people often relate to a baby with the courteous respect other people too often reserve only for adults. If given a chance, they may accurately and wisely interpret their baby's actions and responses to the professional people trying to serve him.

The interplay between such parents and clinic staff members is often a series of dynamic unfoldments. The parents may ask a medical question. To make rational reply, the staff member will seek further individualized information about the baby and question the parents. The parents then respond with their own astute observations—not a pious recitation of something read in a baby book or child-care article, but a clearcut bit of real-life data—"He doesn't like it, Doctor." "Oh?" "No. It scares him." "Scares him?" "Yes. I reckon it slips on his tongue." "How can you tell?" and so on and so on. In thus contributing keen observation and interpretation, the parent is in partnership with the professionals serving him and his child.

One woman illustrating this phenomenon was a domestic worker from a Caribbean island who had moved to a large city in the United States. Books were no help to her, although she could read advertisements, warnings, and other brief communications. On becoming pregnant, she sought maternity and pediatric care and utilized both well, but in a rather mechanical way as though to oblige the doctors and nurses. But about the time the baby began to watch

and respond to her facial expressions, she developed a whole new maternal approach.

This warm, intuitive mother became a revelation to all who had the privilege of observing the developing relationship between her and the baby and her way of meeting the baby's needs. A physician and group of nursing and medical students were with her one afternoon in the clinic examining room where a defective cabinet hinge always made a harsh sound whenever the cupboard door was opened. The mother stood there, cuddling and patting the drowsy 16-week-old baby. Both seemed partly asleep. Suddenly a nurse opened the supply cabinet and the rasping noise screeched through the room.

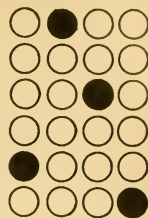
The baby shuddered, clutched his mother's blouse and looked not at the noisy cabinet but to his mother's face, as though for interpretation and reassurance. He got both. The woman who for a moment may have been as startled as the child, now crooned a gentle, wordless sound, patted her baby, and carried him over to the offending cupboard. There, in a soft whisper, she told the baby exactly what that shocking sound had been.

The baby watched his mother's face absorbedly relaxed, and sighed. He may not have understood the words, but he got the "music," and the two of them, mother and child, settled down to their own cozy form of clinic wait, but with deepened bonds of mutual understanding.

Further acquaintance with this mother and child over months of clinic care bore out and further revealed the richness of the rapport and the relationship developing between them. All pediatric care was built on this observable strength. Instead of initiating the progressive steps of pediatric guidance in authoritative and impersonal ways, the clinic staff watched for successive stages of readiness in the mother and child and used them in introducing new steps in care. For example, the mother told of the child's pleasure in plucking at her dress buttons and how he "wanted to eat them"; and this report of "precise pincer prehension" told the staff he was already to employ eye-hand-mouth coordination in finger feeding.

Thus, family health care and pediatrics become increasingly interesting and effective when one diagnoses and utilizes the strength in the people served. This strength-seeking approach to medical care has rewards for patients and for the serving professions. It adds zest and new dimension to services for people from depressed social groups, who too often are underestimated as parents—and as people.

TESTING RETARDED CHILDREN FOR DEFECTS IN VISION



ROBERT T. BLACKHURST, M.D.

EDMUND RADKE

About 250,000 mentally retarded children of school age in our Nation are functioning as best they can with uncorrected defects in vision. The very children who can least afford it may well be educationally short-changed because of the handicap poor vision imposes. And at the present birth rate, another 25,000 babies will be born each year who will be classified as mentally retarded and who will go through school with uncorrected, significant defects in vision.¹

Our estimate of the prevalence of uncorrected defects in vision among these children is based on the result of a program in which 6,158 mentally retarded children were tested for defects in vision. The program was carried on by the Detroit Department of Health in cooperation with the Vision Section of the Bureau of Maternal and Child Health of the Michigan Department of Public Health.

The battery of tests used in the screening included a 20/30 Snellen Test (a test for acuity), a 1.75 plus sphere lens test (a test for farsightedness), and a phoria test (a test for eye muscle balance). Children under 6 years of age, however, were given only the Snellen test.

Standards for these tests have been determined by the Vision Section working with an advisory committee of ophthalmologists of the Michigan State Medical Society. A total of 1,313 children (21 per-

cent) failed the test and their parents were advised to take them to eye doctors (including ophthalmologists, optometrists, and osteopathic eye specialists). According to about 300 records received from doctors, over 90 percent of those examined were found to have significant uncorrected defects in vision. This proportion is consistent with the findings of a larger study completed in Detroit in 1962 based on 2,958 reports from doctors on children in regular classrooms.²

A 1964 report by the Children's Bureau on the health of school-age children in the United States estimated that in 1960 about 10.2 million of the Nation's 44 million school-age children had "eye conditions needing specialist care, including refractive errors," and predicted that, by 1970, if the school-age population rises to 54 million as expected, about 12.5 million school-age children would have serious eye conditions.³ If these defects are not corrected, these children will not be able to develop their full potential, and the problems of the mentally retarded children among them will be compounded by the added handicap of poor vision.

Fortunately, there is a growing awareness of the importance of good vision to good learning.⁴⁻⁷ The eyes, after all, are the principal instrument for learning.⁸ Yet, according to surveys we have taken in Michigan involving many thousands of children, one out of every three will have a defect in vision needing correction by the time he reaches high school graduation age (and even today we are not discovering and correcting all the eye problems of schoolchildren).

Based on a paper presented at the 1965 annual meeting of the American Public Health Association and the American School Health Association.

Robert T. Blackhurst, M.D., left, an ophthalmologist and a surgeon, is chairman of the subcommittee of ophthalmologists, Child Welfare Committee, Michigan State Medical Society. Edmund Radke, right, is chief of the vision section, Bureau of Maternal and Child Health, Michigan State Department of Public Health, and is also chairman of the Committee on Eye Health of the American School Health Association.



dren will look through their glasses, at least for close work, as long as they are able to see at all. Because this child apparently could see more easily without glasses, she was referred for care—that is, on the basis of our recommendation, her parents were advised to take her to an eye doctor. (The public health nurse of the local health department follows up referrals to see that something is done for the child.)

The next child we referred from observation had glasses that did not fit properly. The temple piece bowed out as if the frames had been outgrown, and the lenses were tilted. (The importance of properly fitted glasses cannot be overemphasized for two reasons: Children may not wear glasses that are uncomfortable; and poorly placed optical centers may induce horizontal or vertical distortions that cause strain.)

The third child we referred on the basis of observation was a boy whom we suspected of having eye trouble because he had his head buried in his work. The teacher confirmed our suspicions that this was his usual behavior. Several explanations were possible, though extreme nearsightedness or subnormal vision were the most likely causes. In any case, definitely needed the attention of an eye doctor. (A third possible explanation is that his problem was psychological and no defect in vision may have been present. He might have been one of those children who simply wants to get close to things even though

Because of the success of testing in Detroit, we believe that educable mentally retarded children can be tested for defects in vision with little or no modification of the procedures used with children in regular classes. The vision technicians who conducted the testing in Detroit reported that "the children paid close attention to directions, were cooperative, and were, if anything, even more polite than children in the regular classroom." They also reported that not one educable child was incapable of being tested.⁹

Testing the severely retarded

Obviously, not all mentally retarded children can be tested so easily, but testing procedures can be adapted to the ability of children who are more than mildly retarded, and it is most important that they be tested.

On a recent visit to a class of 14 severely retarded children we found good examples of how even severely retarded children can be tested for defects in vision by observation and by tests adapted to their ability. Moreover, the results of the tests given by a vision technician point out that many mentally retarded children may have undetected defects in vision. A staff photographer accompanied us to the school, and subsequently our department's office of health information produced a film of the proceedings.

On arriving, we asked the teacher in charge to continue her routine so that we might watch the children at work before formal testing began because symptoms of defects in vision may often be detected by observation alone. On this basis, we were able to refer several children.

As we looked about the room we saw a girl who consistently looked under the lenses of her glasses, apparently because she saw better without them. Her unusual conduct attracted our attention: Most chil-

Figure 1.—By observation the authors knew this little girl had eye trouble. She moved her eyeballs rapidly from side to side, a symptom of nystagmus, and kept her head tilted.



their eyes are normal—they want to get “inside” a book or close to a drawing.)

We then observed the children at close range. From this observation, we referred a little girl whose eyeballs were moving rapidly from side to side and whose head was tilted. (See fig. 1.) Apparently she had a form of nystagmus, a not uncommon defect among children. In nystagmus, of which there are many types, the eyes may exhibit a vertical, horizontal, or cyclic movement. In addition, there is a form of searching nystagmus in which the movement may be a combination of all three (this is a type often seen in infants with subnormal vision in whom the inability to fixate an object results in a continual searching). It is this type we most often encounter in mentally retarded children. Children with nystagmus usually see better when they look through the corners of their palpebral openings and with both eyes open. As a rule, they may see several lines better on a Snellen chart with both eyes together than they do with either eye individually. The fact that this girl kept her head tilted might have been an indication of more than one defect. If a child consistently looks at objects with his head turned or tilted, or with one eye closed, he should be referred. Closing one eye suggests faulty binocularity.

The next child who drew our attention was a boy whose left eyelid was drooping enough to interfere with his field of vision. He appeared to have ptosis,

as this defect is called. Although the left eyelid drooped more than the right, both eyelids appeared to be involved. He used the muscles of his forehead (the frontalis) to keep his eyelids out of the way of his sight. Correction of ptosis requires surgery.

Up to this point, we had referred 5 of the 14 children simply on the basis of observation.

Testing of the other children required more formal methods. The vision technician then used the corneal reflection test. In this test, the technician shines a beam of light toward the child's eyes at a distance of about 30 inches in a direct line between the two. If vision is normal, the reflection from the light falls simultaneously in the center of each pupil. If, however, the child has a defect involving the ocular muscles such as a crossed eye, the light falls in the center of one pupil but off center in the other. This test is well suited for children who are either too young or too immature to cooperate in more elaborate testing.

One boy was referred for treatment on the basis of this test. In his case, the reflection appeared on the pupil of one eye and below the pupil in the other, an indication of hypertropia. (See fig. 2.) In addition, we noticed that more of the sclera was visible beneath the boy's left cornea than below the right, so he obviously had a left hypertropia. In this disorder, any of the eight muscles (four to each eye) used in the vertical movement of the eye may be involved. The doctor must work quite a bit with a child having this

Figure 2.—A beam of light, shone in this boy's eyes by the technician, appeared on the pupil of one eye but below the pupil in another, a sign of the disorder hypertropia.



Figure 3.—One boy who would not speak was given a wooden E which he could turn in the same direction as the E used in the Junior Vision Screener, a test for acuity.



disorder to determine what treatment will be effective. In any case, the light reflection test will verify the presence of a deviating eye that might otherwise be missed in other forms of testing.

The next screening procedure was to test the visual acuity, insofar as it could be measured, of the other eight children. For this test, the technician used the Michigan Junior Vision Screener,¹⁰ an instrument developed to test the vision of preschool children. It employs a Snellen E, which is presented as a 3-legged table in a frame of reference familiar to a young child. The vision technician plays a game with the child and asks him to tell which way the table legs are pointing.¹¹ This test works well with both normal preschool children and older mentally retarded children.

Using this instrument, we were able to test the other children successfully, two of whom failed the test. Each child was tested at a 20/30 level, first with both eyes and then with each eye separately. Care was taken to see that the method of testing assured that the child understood the test and that communication was established between the child and the technician. For instance, one boy would not speak. To test him, the technician gave him a wooden E which he could manipulate and turn in the same direction as the E in the instrument. (See fig. 3.)

Four of the children responded so well to the Snellen E test that they were then tested with the same battery of tests used with educable mentally retarded children. A stereoscopic instrument containing the three tests (Snellen chart, plus lens, and phoria) was used. One failed the plus lens test, another the phoria.

When all screening had been completed, we found that 10 of the 14 children were to be referred for eye care. This was a higher number than we would ordinarily expect to find.

Using techniques such as those discussed here, vi-

sion technicians throughout Michigan will soon be testing children in classes for the mentally retarded. If sufficient attention is given to the kinds of test administered and to the testing procedures, the skill of trained technicians will ensure a successful screening program.

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³ Lesser, Arthur: Health of children of school age. U.S. Department of Health, Education, and Welfare, Welfare Administration, Children Bureau. CB Publication No. 427. 1964 (reprinted 1965).

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⁵ Anderson, Ursula M.: Reading disability—what should the school physician look for in determining its causation. *Journal of School Health*, April 1965.

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⁷ Gunderson, Doris V.: Research in reading readiness. U.S. Department of Health, Education, and Welfare, Office of Education. Bulletin No. 8, OE-30013. 1964.

⁸ National Medical Foundation for Eye Care (now American Association of Ophthalmology, Washington, D.C.): Identification of school children requiring eye care—a report to educators and physicians. New York. 1959.

⁹ Mehr, Kenneth et al.: Vision screening in selected classes for the mentally retarded, City of Detroit. Vision Section, Division of Maternal and Child Health, Michigan Department of Public Health, Lansing, February 1965.

¹⁰ Blackhurst, Robert T.: Successful preschool vision screening in Michigan. *Journal of the Michigan State Medical Society*, September 1962.

¹¹ Austin, Caroline: Mass preschool vision screening. *Children* March-April 1959.

The most meager background will do, if the world the child meets can do just that little fancy footwork to be ready for him. If we stay stuck with one favorite color—white, and one favorite style—verbal, and one favorite background—middle-class, we make the love affair between the child and his world the rare privilege of a favored few, instead of the prized outcome for all.

James L. Hymes, Jr., Education Professor and Director of Nursery School-Kindergarten, University of Maryland, to the Association for Childhood Education International Conference, New York, 1965.

A REGISTRY ON CHILD ABUSE

WILLIAM H. IRELAND

On July 1, 1965, the Illinois Department of Children and Family Services established a central registry of abused child cases, under

the mandate of the State's new law requiring physicians and other practitioners of the healing arts to report all cases of suspected child abuse. This has made it possible to get a clearer picture of the nature and extent of child abuse in the State. For example, in the first 9 months of its operation, the registry received more than twice the number of reports of child abuse as had been anticipated. The bulk of the reports came from the Chicago area, but cases were also reported in all eight geographic regions in which the department has regional offices. "Beating" was by far the most frequently reported type of abuse.

Thus, a central registry of cases of suspected child abuse is comparable to the communicable disease registry commonly used in the public health field. Incidence of communicable disease, subclassified by type, locality, time of occurrence, and population affected, is indispensable to health authorities in developing and coordinating measures to control disease. The gathering of similar data on the incidence of various types of social malfunctioning could be useful in designing effective methods of control. A central registry on child abuse is a step in this direction.

Ideally, a central registry should make possible (1) definition of the problem; (2) the development of a logical program for its control; (3) the planning of recording methods and procedures for the administration and analysis of the program; and (4) the evaluation of the program. Obviously, these functions cannot be accomplished simply nor simultaneously.

How a central registry will operate depends on a variety of factors, but basically it must be related to the law governing reporting of suspected abuse. The points in the law which are relevant to the operation of a registry are: (1) What shall be reported?

(2) Who shall report? (3) To whom shall they report? (4) When shall they report? (5) What shall be done upon receipt of report?

In Illinois, the Child Abuse Act, passed by the 1965 legislature, requires hospitals and physicians, surgeons, dentists, osteopaths, chiropractors, podiatrists, and Christian Science practitioners to report on children whom they have cause to believe have suffered injury, disability, physical abuse, or neglect inflicted by other than accidental means. The reports are to be made immediately by phone or in person to the nearest office of the Department of Children and Family Services and, also, in writing within 24 hours after examination of the child. Reports may also be made to the local law enforcement agency, but, if this is done, the Department of Children and Family Services is to be so informed. In addition to maintaining a central registry, the department is required to investigate the cases reported, to offer protective social services to prevent further abuse or neglect to the child, to safeguard his welfare, and to preserve and stabilize family life whenever possible.

The Illinois Department of Children and Family Services provides statewide protective services through 8 regional offices and 25 district offices of its Division of Child Welfare. The responsibility for the operation of the central registry on abuse resides in the Department's Division of Planning, Research, and Statistics. Through the coordinated planning of these two divisions, the reporting procedures, service program, and central registry were in operation on July 1, 1965, the first day the act went into effect.

The reporting system

The central registry records only those cases reported by a hospital or members of the professions designated as responsible for reporting under the law.

William H. Ireland has been with the Illinois Department of Children and Family Services as chief of the Division of Planning, Research and Statistics since 1964. Previously, he spent a total of 18 years as director of welfare councils in Seattle, Wash., and in Akron, Ohio, and on the staff of the United Fund of Greater St. Louis.



In addition to the information required to be reported, its records contain certain items that assist in observing compliance with the law, and some characteristics of the child, the family, and the abuse situation.

The registry is tied in with the child welfare division's regular service accounting system so that additional information about cases receiving service or care beyond the initial investigation may be obtained. The registry's procedures are designed to speed the forwarding to it of all pertinent information about each case at the time the information is obtained.

When a child welfare worker in a regional or district office receives an oral report of suspected child abuse from a medical practitioner or hospital, he records the information on a duplicate form, a copy of which is retained in his office and another copy sent immediately to the central registry. The information in this first report includes the date and time the oral report was received; the name, address, sex, and age of the child; the names and address of the parents or persons having custody of the child; where the child was first examined; the name, address, and telephone number of the reporter; the date the child was brought to his attention and by whom; the nature of the child's condition, including any evidence of previous injury or disability; the child's present whereabouts and the reporter's immediate plan for him; the types of abuse suspected; the person or persons presumed to have inflicted it; and the worker's judgment as to the seriousness of the immediate situation.

The written report from the practitioner or hospital is made on the practitioner's own letterhead or on a form provided to hospitals by the department. The original copy is retained in the regional or district office to which it is sent and a facsimile immediately forwarded to the central registry.

As soon as a case is reported to a regional or district office, an investigation is made, and, if necessary, service to the family and child initiated. After the

initial investigation the worker sends a brief report about the family to the registry. Because this type of investigation is a major service responsibility, the worker is allowed up to 10 days to report on it.

The worker's followup report to the registry includes, besides the necessary identifying data, information on the composition of the family or household, including the marital status and ages of the heads of the household; the names, sex, and ages of the children and their relation to the heads of the household; the names, sex, and ages of others living in the household and their relationship to the child; the names, sex, ages, and whereabouts of any of the children's siblings who are not a part of the household; whether the allegation of abuse was admitted by anyone in the family and if so by whom; the parents' or caretaker's explanation for the child's condition; and whether or not there is a history of any previous instances of child abuse in the family. The reporting form also includes space for additional remarks.

The worker's followup report also indicates whether or not further service is to be provided to family or child by the department or through other agencies. If so, further records and service accounting are made in the same manner as in any child welfare case. In Illinois, information on all child welfare cases, whether public or voluntary, is kept by the department's statistical section in a central index of child welfare services.

In the interest of brevity, the reporting forms to the central registry of child abuse cases have been made especially succinct. For example, the term "abuse" is used to cover abuse, neglect, or injury. The term "suspected abuse" does not appear on the forms although it is understood that there may or may not have been a determination of actual abuse at the time of the report.

Use of information

Department staff members in the regional or district offices may contact the central registry at any time to learn whether or not a child has ever been reported for abuse. Since the central index on child welfare services and the central registry on child abuse are closely correlated, the same inquiry may elicit information on whether or not the child's family is being or has ever been served by the department or any of the voluntary child welfare agencies licensed by and reporting to it. This optional procedure may be interpreted as a diagnostic aid or simply

ly as a means of reducing duplicate efforts. It is diagnostic in the sense that a child or family that has been reported previously on suspicion of abuse can be identified and the worker directed to the source of more detailed information. Even if no previous report of abuse has been made on the family, a cross check with the index on child welfare services will reveal whether the family has previously been served by a child welfare agency and so may make it possible to get further background information to assist in diagnosis or service.

Persons outside the department, including physicians or law enforcement agencies, do not have direct access to the central registry, since the same principle of confidentiality of information applies to it as applies to all department case records. However, persons who have reported, or are contemplating reporting, a case can receive helpful diagnostic information and assistance through consultation with the child welfare worker in the region or district to which the report was made. This direct consultation improves interprofessional relationships. In addition, it saves the inquirer a long distance telephone call to the State capital since the nearest office of the department will probably be in his own community, or, at the farthest, 5 miles away.

The Division of Child Welfare also investigates complaints of neglect or abuse coming from sources other than those named in the Child Abuse Act, and provides whatever services seem indicated. Such cases, however, are not entered in the central registry unless a medical examination of the child is made and injuries reported.

In short, the design and operation of the central registry on abused children in Illinois takes into account the fact that it is established by and operates in accordance with the law. While some minor adjustments in form design and procedures, shown by experience to be needed, are now being made, the basic operations will remain the same.

he results

Though the central registry has been in operation only a few months, its usefulness has already been demonstrated. It has alerted workers to possible duplicating efforts in a few cases, but this clearing nature has been of lesser importance than the epidemiological function, possibly because of the short experience. There has been no evidence of the "shopping phenomenon"—taking an abused child to a different hospital or practitioner each time he is injured.

Again, this may be because the registry has not been in operation very long.

There is, however, indication that those who are required to report suspected abuse under the act are doing so. In the first 9 months, 363 children—200 boys and 163 girls—were reported as suspected victims of abuse. Nearly 90 percent of these reports were followed up by written reports.

The majority of reports, 302, came from hospitals. In addition, physicians reported 51 cases from their private practice. Other sources accounted for 10 cases.

The types of abuse suspected were: beatings (221), fractures (48), malnutrition (47), burns (33), and "other" (60). Under "other" were stabbing, neglect, lacerations, poisoning, sexual assault, gas inhalation, and failure to administer medications. Type of abuse was not reported in 12 cases.

The persons suspected of the abuse were: father (109), mother (136), stepfather (21), stepmother (11), sibling (4), and "other" (73). Under "other" were babysitters (21), relatives (14), neighbor (7), foster parents (4), and miscellaneous and unspecified (27). In 46 reports, no suspected person was noted.

Severity of the child's situation was indicated as "emergency" in 42 cases, severe in 89, moderate in 161, and not reported in 71.

The children reported as abused ranged in age from under 6 months to 16 years, but the great majority, 247, were under 5 years of age; 99 were under 1 year, including 59 under 6 months.

Since the passage of the Child Abuse Act, the department has received numerous inquiries from the community about how well the act is working. These could be—and have been—answered promptly with facts on the number and primary characteristics of cases in the central registry. If need be, the number of children reported to date, sex and age distribution, source of reports, types of abuse, and by whom the abuse is presumed to have been inflicted can be tabulated daily.

Thus, the central registry assists in alerting the public to the nature and extent of the problem of child abuse in the State. It is dependent upon and serves physicians and other health practitioners, as well as the workers in the Department's Division of Child Welfare, who bear the responsibility for protection and service to children and their families. Finally, it provides a base for indicating the incidence of child abuse, further defining the problem, and aiding in developing and analyzing a program to deal with it.

EMMA SHIEFMAN

a schoolteacher in a child welfare agency

For many years school systems of most large cities have employed visiting teachers or school social workers because they recognize that there are aspects of a child's development which, though not the school's direct concern, may directly affect his school performance. In contrast, scarcely any social agencies, other than institutional care agencies, employ teachers. The Detroit Foster Homes Project, my employer, is an exception. Sponsored by the Merrill-Palmer Institute of Human Development and Family Life with a grant from the National Institute of Mental Health (5R11-MH-01551-03), the project was set up to demonstrate that children who have lived in many homes, who have been subjected to marked family disorganization, and who show disturbed behavior, can be placed and kept in "highly reinforced" foster homes. Douglas A. Sargent, M.D., is its director.

My first contact with the project was as an independent tutor for one of its boys. This assignment grew into a staff role as educational consultant and therapeutic tutor and member of a team which includes caseworkers, group workers, psychologists, and a psychiatrist.

There are five fundamental reasons for a social agency working with children to have a teacher on its staff. They are:

1. The child's most important relationships outside the home are in school, for there he succeeds or fails, reveals his mental health or emotional disturbance, as the adult does in his occupation.

2. A deprived child with emotional problems is

extremely prone to develop learning problems which in turn, lead to additional emotional problems.

3. In school and in tutoring, a child may show side of himself he does not show at home or in social work contacts. Sometimes the teacher or the tutor uncovers clues to difficulties which are helpful to the social worker in working with a child. For the child who is too old for play therapy, the tutoring session often serves the same function. It may seem silly for him to talk about himself, but it does not seem silly to talk about people in stories.

4. The emotionally disturbed child who learns with the help of a social agency's tutoring and school program acquires strength for meeting emotional problems. The sense of mastery which successful learning brings may be the first feeling of success for a child who has known only failure and rejection. This feeling may give him his first reason for believing that conditions can change, his first clue to understanding of his environment. The most important result successful learning offers such a child is the ability to use language with which to express and identify his feelings and, so, to work them out in less physical and more mature ways.

5. If the school's environment is benign, it can foster changes; if hostile, it can undo months of work by a social worker. In either case, it is an environment that can be changed by one familiar with the organization and operation of the school. A skillful teacher can influence other teachers and administrators, work assignments, and special activities.

Since the project began 4 years ago, it has placed

5 boys (10 Negroes and 5 Caucasians) in "highly enforced" foster homes and has provided 7 with therapeutic tutoring in language skills, with promising results.

Three case histories

The case histories of three boys—Allan W, Keith, and Chuck T—who have been tutored for over a year show how progress in overcoming learning problems can help overcome emotional problems in some children.

Deserted by his mother when he was 6 months old, Allan W is in his fifth foster home when tutoring began 2½ years ago when he was 8. Although of normal intelligence, he was unable to read and was in an ungraded class. He was a small, egotistic boy, full of fears and suspicions, and troubled by urticaria, headaches, stomach cramps, rashes, and nausea. He could not be restrained during lessons. His psychiatric evaluation said in part: "He shows an impulse-ridden character in a child who has been extremely deprived and neglected. His capacity to relate to people is impaired."

An unfavorable foster home added to Allan's troubles. His foster mother was weak, cold, and rigid. She could not tolerate his vile language, for instance.

But Allan got intense gratification from the one-to-one relationship of the tutoring, for in tutoring he could accept solicited bounties such as complete acceptance by the tutor or readily and could open up more easily than in the more threatening social work interview. As our relationship deepened, I found he has searching curiosity, playful fantasy, and an artist's eye for details. He developed pride in reading as he mastered the skill. His enuresis was controlled under the guidance of the social worker, and his psychosomatic ailments diminished. He was moved to a 2B and then a 2A class.

A year and a half after tutoring began, Allan met a challenge that might have been crushing. His foster mother became ill and used her illness as a pretext to give him up. Allan owed great strength in making the change to a new home, through which, I believe, grew out of his gratification in the tutoring relationship and his pride in reading. Fortunately, the new home is much better for him: The mother is strong and firm, and there are two other adopted sons near Allan's age.

The change of families brought a change of schools. His first was an inner city school with large classes and overworked teachers; his new, a beautiful building in the suburbs. Classes are small. When Allan enrolled, conditions were nearly ideal: the principal was elderly and compassionate, and his teacher was young, pretty, and very skillful. In this environment Allan grew as never before. He became a member of the group, a compassionate leader, the third best reader in the class, and the best friend of the best reader, a white boy. He grew more independent, could tolerate disappointments, and could be trusted to remain after school for special activities. He became protective of his younger brother and adoring of his older. He even changed physically; he looked straighter, younger.

Allan was doing so well we began to plan to end tutoring.

But what the school gives it can take away. Conditions changed for Allan with a new teacher and a new principal. The new teacher was in her first position and faced a very difficult class. The new principal had his hands full replacing a dearly loved woman (who had retired) in the only truly integrated school in the community. At first, he seemed more concerned with running an efficient school than with the problems of individual children. These changes upset Allan. He got into a fight, and the principal threatened to expel him (an action which would have forced us to remove him from his foster home).

Through the strenuous efforts of almost everybody from the agency, the situation was smoothed over. With our help, his teacher gained confidence, and Allan grew to love her. But 3 months later she moved away; Allan has had two more teachers since she left, the second, a no-nonsense type. He has been in fights and has even run away from school. The principal has again threatened to expel him, and again we had to step in with all our resources.

Nevertheless, Allan seems to have enough strength to live through these problems and to grow. He has so completely identified himself with the agency's goals that he talks of what will happen to him when he is in high school, and has even mentioned college.

Allan's tutoring ended last June, though we planned to resume it if necessary. But in September, his principal assigned him to an experienced, sympathetic teacher under whom Allan is doing very well. My only contacts with him now are on occasional visits to the home to bring books or a gift for a special occasion. He reads nearly every book I bring him.

* * *

Keith C, another boy who has received tutoring for a year or so, had been brutally treated by his psychotic mother. When I first saw him (he was 10), he almost completely lacked expression and language, though he is of average intelligence. He never asked questions, would only answer yes or no, and would shy away from other people. Yet he seemed strongly motivated to learn, as though he needed answers to the questions he did not dare ask.

Last fall, after I discussed Keith with her, his auditorium teacher let him read for the part of "an echo of President John F. Kennedy" in a play to be given for parents. The first time I went over the script with Keith he didn't know at least 50 words and couldn't pronounce others. But he practiced at home, with me during lessons, and in long sessions on my dictaphone. He got the part. After the program, Keith told

Emma Shiefman, who joined the staff of the Detroit Foster Homes Project as a tutor and educational consultant 2 years ago, received her training as a remedial reading teacher at the reading clinic of the Educational Psychology Department of Wayne State University. Previously, she had spent nearly 20 years in the field of early childhood education—as a teacher in Detroit's public kindergartens and as a preschool teacher and director in various types of nursery schools.



me, "I was a little bit nervous, but not a whole lot. I thought I sounded like him [President Kennedy]."

Keith's principal says of him, "He's a different child now. He even looks different." I agree. His personality has become more open; he doesn't seem so confused. He asks questions (still not the ones that really bother him), and he is able to talk a little about his feelings with his social worker.

* * *

Chuck T, who also started tutoring about a year ago at age 10, was infantile, narcissistic, and unwilling to accept reality. His teacher said he sat in class like a vegetable, never trying.

One day, a few weeks after tutoring began, when I brought Chuck to my home for a lesson, he saw the dictaphone and seemed interested in it. As he had been to the circus the week before, I suggested to him that he use the machine to tell me about the show. We pretended it was a radio interview—"We have a young man here . . ." I said, which delighted him. We transcribed his dictation in large bulletin type, cut out suitable pictures from magazines, and pasted them into a book. He dictated two other stories like the first, and we bound all three in a book, which we titled "Places I Have Been." His foster mother and foster brothers talked to him about it; his teacher let his classmates read it. Their interest made him very proud. It became the first book he read with interest.

From then on Chuck showed interest in reading and in a few months was reading at about his grade level. But he still did no other school work. About 9 months after tutoring started, he seemed relaxed enough with his foster home, his teacher, and me for us to pressure him to perform better. His teacher and I enlisted the help of his foster mother to make sure he prepared for his weekly spelling tests. He responded favorably and soon was making A's on these tests.

Chuck was recently adopted by his foster parents. His mother is taking over much of the school contacts and supervising all the homework—reading, literature, spelling, writing, and social studies. I am still tutoring, and Chuck and I will soon move into arithmetic and science.

Changes of environment

Changing the school environment can mean the difference between success or failure in some cases, the project has found. A child may be in the wrong school, have the wrong teacher, or be in the wrong grade. It is not often feasible to change the teacher, but a change can be made in the school or in the grade.

Take the case of Joe R, now age 13. Joe had attended a class for the mentally retarded with much younger children in his neighborhood school with little progress. We changed him to another school which had special classes for mentally retarded boys his age, including shop work and physical education. His behavior and achievement have improved greatly; he has become an outstanding student, and has even served as a student assistant.

For Paul A, a grade change made a great differ-

ence. Paul was not doing well in an "honors" class in which he had been put because it was the only available alternative to the regular class where his behavior could not be tolerated. The teacher in the honors class was a strong and kind man.

We moved him back one grade, but kept him in the honors class for his nonacademic subjects. Under this arrangement, he kept up with his school work and his behavior improved by being with the serious students in the honors class. Unusually motivated he has made so much progress in tutoring sessions that we have moved him back to the honors class full time. He attended summer school in 1965 and has been keeping up with the class since.

Sometimes we can work a change in the school environment merely by supplying different teaching materials. One of our most difficult boys, John I who was having trouble staying in a special class for emotionally disturbed children, now practically runs to school each morning because he finds the programmed instruction recently introduced to his class so stimulating. For the first time, this boy is working on his own.

The school environment may be changed by helping the teacher change her attitude toward or her way of handling a child. Although there are formal conferences with teachers and principals, most of my meetings with teachers are short and casual—but frequent. When a teacher and I meet, I pass on background information about the child and listen to complaints sympathetically. If all goes well, we become a team to help a child move along in school. Besides helping teachers, when necessary, I take steps to open up opportunities in special school programs such as the band and the safety patrol which may help our boys find success or recognition.

The case histories I have related seem to say that everything good has happened to these boys happened in school or in the tutoring session. Obviously, that is not true. Skillful caseworkers, group workers, and psychologists helped move these boys to express their feelings, to understand themselves and to change. In addition to exchanging ideas and records, teachers and social workers plan educational strategy as a team, and when the project assigns workers to a boy's case, his educational adjustment is one of the first aspects discussed. The point I have tried to make is that progress in learning and improvement in the school environment through the work of a teacher on the agency's staff created conditions under which the professional social worker could be more effective.

A NEW THEORY OF DELINQUENCY? IT'S ABOUT TIME!

FRITZ REDL

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“Family of Outcasts: A New Theory of Delinquency” by Seymour Rubenfeld* is easily the most exciting book written about delinquency for a long time. Before you pick it, however, you should know that you are in for. When the author says this is a “theory of delinquency,” he means what he says. And if you think you are going to get a bag of trick prescriptions to help you handle “junior” after he swiped somebody’s wallet, or to run a delinquency prevention program on a shoestring, you will be disappointed. In fact, anybody who is still looking for some quick means of preventing something as serious as delinquency should read the last few pages of this book. They contain the most sobering warnings against under-estimated, spray gun solutions for the problem of delinquency that I have ever seen put into such a short space. The reason I wax so enthusiastic about this book should be made clear, though I cannot in a few summary paragraphs here do justice to the full extent and complexity of the author’s arguments. After all, he had a whole lot to make his points.

One of the great merits of this book is that it takes seriously the silly split between the sociologists and anthropologists—at least some of them—on the

one side, and, on the other, the clinicians, especially the psychoanalysts and all others who are still convinced that there is something to personality theory after all.

I fully agree with the author that we have dallied too long in an obsolete either-or stance. Here are his points:

1. Some sociological research has been too one-sidedly focused on an oversimplified “opportunity theory”—as though everything that ever makes a youngster delinquent could be reduced to lack of money, girls, and jobs, or to the anger about blocked upward mobility, socially and economically. And even more, some sociological writings even breathe downright hostility toward anything that is even remotely “psychiatric” or tries to remind people that kids do sometimes have problems before they want girls, cars, or money, that some degree of “pathology” exists in every level of social caste or class, and that all adolescent delinquents have had a childhood behind them, too.

2. Clinicians have indulged for too long in an exclusive reliance on “libido theory” alone, without recognizing the advances of ego psychology. Though he does rap sociological knuckles for exaggerating this point and for making strawman enemies out of the discards of the psychoanalytic past, Rubenfeld tells us in no uncertain terms that we cannot continue to avoid coming to terms with the sociological and culture-anthropological findings.

It seems to me that the difference in the way the two theory-camps “discommunicate” with each other is an interesting issue in its own right. I am impressed with the wrath against anything psychiatric or even remotely case-history oriented in which at least some of the opportunity-theorists indulge. The personality and clinical camp, on the other hand, seems to be accepting, rather than fighting, sociological data and theories, but avoiding coming to grips with them. In fact, most of what sociologists have taught us is by now so well accepted by persons trained in personality theory such as residents in psychiatry that I am constantly amazed at finding all that stuff about class in their own diagnostic writeups, without any apparent awareness on their part that it has been smuggled in by the sociological backdoor and has not always been part of psychiatric lore.

Professional blinders

Some of the excitement in reading this book comes from watching one who is thoroughly familiar with and acceptant of both sociological and psychiatric fields arguing against both sets of blinders, and in a way which could only be done by somebody who has thoroughly studied and has had experience of his own in both areas. However, I suggest that readers who are eager to get at Rubenfeld’s “new theory” start with page 183 or even page 234, and read the rest afterward. The author engages in a most scholarly battle with

*Rubenfeld, Seymour: *Family of Outcasts: New Theory of Delinquency*. The Free Press, New York. 1965. 328 pp. \$5.95.

practically everybody who ever said anything in either field, with fascinating arguments and plenty of documentation, but it takes him a while to get to what he himself really has to say—and that is plenty!

Reweaving needed

The major challenge of this book is its insistence that a new reweaving of theories is what is really needed. Says the author in effect:

- Let's stop talking past each other and hanging on to obsolete either-or issues.

- Let's not only bow to each other's theories and grant generously that maybe the other guy also has something worthwhile to hang on to, but let's also see whether we can really weave the best of personality theory and clinical experience together with some of the more pungent findings of sociocultural research.

In his own weaving job, it seems to me that on the clinical side of the fence Rubenfeld picks up most clearly where Erikson¹ left off, while on the sociological-cultural side he relies not so much on one focal theorist, as on a whole slew of them. Maybe Merton² and Parsons³ stand out, but all the others, including those who got their knuckles rapped in the previous section, such as Cloward and Ohlin,⁴ are respectfully drawn upon.

And now comes the point in discussing this book where I am in for serious trouble. Naturally I became curious, as any reader will, by the time I reached the chapter containing Rubenfeld's own theory, to find out what a "new theory" would look like. However, I find it totally impossible to do justice to what I found in less space than the author had for his job—which was 120 pages! All I can try to do is to give the flavor through excerpts. Anything else would be a naive oversimplification—the very thing this book so bravely fights against.

Under the heading of eight "psychocultural propositions," Rubenfeld describes his agreements with and differences from other researchers and theorists. Then he launches a description of his "paradigms" which contains the major part of his psychocultural weaving job. These are based on what he describes as four "psychocultural processes" which may lead to delin-

quency, "... producing young norm-violators who are neither 'sociological' nor 'psychological' delinquents." Such delinquents are "normal" in their respective subcultures. They may even evince psychiatric symptoms to lesser degrees than some of their conforming (but self-discontented) peers. The latter may be symbolizers while the delinquents may be externalizers."

Each of these processes, as described by Rubenfeld, "is introduced by a consideration of a particular set of sociocultural constraints, operating at one of four social levels—LL [Lower Lower], UL [Upper Lower], LM [Lower Middle], or UM [Upper Middle]." Thus he prepares the reader:

Personality adaptations of some people to the set of constraints affecting their class subculture are indicated. Family relationships and childhood experiences which follow from these adaptations are then considered. The effects of these relationships and experiences on prospective delinquents are also discussed. These personalized consequences are then carried through to description of four different kinds of identity crises, each crisis accompanied by different reasons for delinquency—different pressures, that is, for deviance.

Obviously from here on no line of the author's story can be omitted without giving a false impression of the whole. All a reviewer can do is to give the flavor of some of the passages, hoping that they might induce the reader to run and see for himself. However, it does bother me that Rubenfeld sticks to the somewhat antiquated Warnerian⁵ categories of LL, UL, LM, UM—but then, after all, he can't really be expected to start afresh with everything that needs reformulation.

Some excerpts

Here are some tastes of his discussion of "Process IV":

Some UM [Upper Middle] people disregard their own worth in their slavish devotion to the ideology of success. They believe that they are nothing other than what the world says they are. Consequently, they are driven to acquire adulation and power in their interpersonal relationships as much as in the success symbols they seek. They are vain, exploitative, and insensitively self-serving marriage partners and parents. Often, they want to be worshipped by their marriage partners; and, often as not, this desire is defeated by private

guilts and inadequacy feelings, stemming from developmental experiences which predispose them to a feverish pursuit of success.

The UM delinquent of this fourth process is a cynic who has had so many articles of faith traduced that his youthful capacity for devotion has failed. . . . His parents are thralls of success; the belief in power and status. They have exaggerated the significance of opportunity as a value and have oversimplified it to mean opportunism. They translate individuality into careerism, an initiative and industriousness into ruthless self-service and exploitation.

. . . The Process IV youth may present the same callous and self-indulgent view of life's purposes and of relation with others. But he will do so in gross, adolescent way, "with a bark or and without the superficial niceties manner and the pleasantness with which his parents have learned to decorate their secondary relationships.

Underlying this boy's suspension of belief lies a history of betrayals and broken faith by his parents toward some of the most essential feelings about himself. His delinquency is a flight into a negative identity from his scorn for a beginning ideological commitment, essential to resolution of the identity crisis. Though his scorn for new commitments mer respect on its face, it also masks the backward-looking, fearful tenacity of insecure child.

And, in summary of several points made under the heading of "Delinquency as a Social Protest—Résumé":

Each delinquent type that I have discussed is in some way aware of the cultural adversities besetting him and directing his efforts against them; he not just responding in terms of the gross impulses and restricted relations bestowed on him by these adversities. In each process, for example, a negative relation that the dominant classes have to the class level in which the process occurs may be specified; one can specify behaviors by which the delinquent seems to symbolize his rejection of the relation that the normative order in a sense forcing between him and its

In Process I [Lower Lower], a lack relatedness among members of marginal groups results in an infantile character formation in youth which strains toward unlimited power and gratification. The destruction of character was initiated by ostracisms. . . .

In Process II [Lower Middle], a belligerent mother's son shares and suffers from a subcultural resistance to male authority. The relation of dominant groups, in the European peasant origin of this process and in our contemporary society, to class level involved is one of exploitation for economic advantage.

the relatively favorable position of American industrial labor does not detract from the basic consideration that, Fromm says, "the employer has bought the services of the worker, and however human his treatment may be, still commands him, not on a basis of mutuality, but on the basis of having bought working time for so many hours a day. . . ."

Delinquency is an adaptation to current realities to be sure, but it is a halfhearted attempt to maintain that this quality is its most significant aspect. Adolescence grants freedom to know and act against unfavorable truth; but legal childhood has and some to personal legacies of unchability, servility, inferiority, alienation. They are not only subjects acting against a reality inimical to their interests, but they are also the objects of that same reality. It is probably this duality which is off so much of the theoretical controversy in delinquency studies, and that is, I suppose, preprocessed this writing. In fact, it may be said that this theory differs from others in that it takes into account both resentment and rebellion as necessary conditions in delinquency. Social theory stresses delinquency as protest; psychological explanations, generally dwell on manifold clinical forms

of resentment in delinquency. This theory maintains that much delinquency is generated only by the dialectical tension between resentment and rebellion. If either is predominant, the inner dialectic disappears, and the deviance that emerges is something else, not delinquency. Without conscious rebellious impulses the resentful individual displays clinical symptoms. If the force of resentment were much weaker, many delinquent youth might adopt the more positive ideologies and actions of social and political protest movements. The truth . . . lies somewhere between.

There is no question in my mind that Rubenfeld's "new theory of delinquency" will elicit a wide range of excited responses. There will be many disagreements on subissues or on facts, there will be sharp criticisms on theoretical and conceptual grounds—there may even be questions raised as to whether this really is a "new theory," or whether it is rather a challenge to develop one.

I myself could find raising questions

under any one of these points worthwhile, but have neither the space nor the time in which to do it. And after all, why start criticizing a new theory? Let's first be happy and overjoyed that we have one to criticize! It is about time!

¹Erikson, Erik H.: Identity and the life cycle. Selected papers. International Universities Press, New York. 1959.

²Merton, R. K.: Social theory and social structure. The Free Press, Glencoe, Ill. 1949.

³Parsons, T.: Social structure and the development of personality: Freud's contribution to the integration of psychology and sociology. *Psychiatry*, November 1958.

⁴Cloward, R. A.; Ohlin, L. E.: Delinquency and opportunity: A theory of delinquent gangs. The Free Press, Glencoe, Ill. 1960.

⁵Warner, W. Lloyd; Lunt, Paul: The social life of a modern community. Yale University Press, New Haven, Conn. 1941.

book notes

THINKING WITHOUT LANGUAGE: psychological implications of deafness. Hans G. Furth. The Free Press, New York. 1966. 236 pp. \$6.95.

The basis of this book is a series of experiments involving nonverbal procedures in various aspects of intellectual behavior in deaf and hearing persons from preschool age to adulthood. From comparisons of the performance of deaf and hearing persons in the experiments, the author has developed an "experiential deficiency" hypothesis at conventional language, as a specific mode of thought, is neither necessary nor uniformly helpful in the development of thinking.

Defining thinking as "any behavior specifically related to human intelligence," the author maintains that the process of thinking and the use of language symbols are separate. When we insist that they are not, he maintains, we add to the deaf person's handicap.

The author's plea for a nonverbal teaching method is not new, he points out, nor without a following as the current interest in the Montessori methods illustrates. In his opinion, if educators could accept the idea that thinking "is foremost doing, acting, behaving, or internally operating" and not just knowing the right word, and if they could agree that "education should primarily teach and develop thinking according to a child's optimal potential," they could "more readily seek nonverbal teaching methods, particularly in cases where linguistic skill is retarded or absent."

THE SHAME OF A NATION. Philip M. Stern and George de Vincent. Foreword by Vice President Hubert H. Humphrey. Ivan Obolensky, Inc., New York. 1965. 182 pp. \$5.

The poor of the Nation—migrant workers, unemployed coal miners, small farmers, slum dwellers, and poor and

lonely old people—are the subject of this "photographic essay," composed of photographs by George de Vincent and case vignettes by Philip M. Stern, revealing the meaning of poverty to the persons enmeshed in it.

The real shame of poverty in the United States, Mr. Stern maintains, is that "an increasingly affluent society has forsaken its poor: ignored or excluded them, lost sight of their needs."

Mr. Stern protests against the way the poor are treated by the public, or "rather, mistreated." He points out that special investigators of welfare departments may police the lives of welfare recipients, large families—usually the poorest—are excluded from public housing projects, a million people are not covered by minimum wage laws, and one out of five workers are not entitled to the benefits of workmen's compensation.

If the poor are to break the bonds of poverty, Mr. Stern asserts, they must have not only education and training, but also a "voice." Granting that it will not be easy to find leaders from among the poor to serve as their voice, he called for efforts to educate the poor

to the "techniques of protest"—protest to "arouse the American conscience and shape the national will."

TOMORROW'S PARENTS: a study of youth and their families. Bernice Milburn Moore and Wayne H. Holtzman. University of Texas Press, Austin, for the Hogg Foundation for Mental Health. 1965. 371 pp. \$7.50.

How high school students view society, parenthood, child-rearing practices, and education is greatly affected by the education of their parents, and their mental health can be correlated with the socioeconomic status of their parents, the authors of this report of a 10-year study of high school students in Texas maintain. The students involved in the study, called the Texas Cooperative Youth Study, were from every section of the State and represented several ethnic groups and all socioeconomic levels.

The study found, the authors report, that students in cities were more resentful of parental authority than students in rural areas, though the pressure to conform was greater in small communities than in large. Students from the lower socioeconomic groups tended to support authoritarian parenthood more than those from the upper levels. Students from highly cultured families were better adjusted than others. And, although more students than the investigators expected wanted to go to college, respect for educational achievement was highest among students with educated parents.

The authors conclude that young people "must remain in school" if they are to perform "the paramount obligation" of their adult lives, that is, "the rearing of children in competent families residing in adequate homes." In their opinion, the family is still the first instrument for the socialization of the young and the transmission of culture.

RECLAIMING THE DELINQUENT by para-analytic group psychotherapy and the inversion technique. S. R. Slavson. The Free Press, New York. 1965. 766 pp. \$9.95.

This book describes a 6-year experiment in treating seven seriously delinquent 15- and 16-year-old boys, undertaken as a "study in action and in depth" to uncover the "mostly un-

conscious inner dynamisms of the delinquent boy in our culture."

The author reports that by use of a "para-analytic method" and the "inversion technique" the boys were put into the analytical and introspective moods necessary to therapy. Para-analytic therapy, he says, concentrates primarily on behavior, a major concern of these boys because they were being punished for misbehavior. In thus concentrating on their conduct in group interviews, the boys were helped to realize that understanding the reasons for their behavior was the key to "their salvation." Once they realized this, the author says, the boys readily participated in group interviews characterized by the "inversion technique": an inversion of attention from outside factors to the inward conflicts that had a part in getting them into difficulties.

The author concludes that the work began too late to be entirely successful, but that more progress was made with the boys than might have been by individual therapy. One of his conclusions regarding the "inner dynamisms" of the delinquent, based on an analysis of the group interviews, is that the boy's sense of identity has been so debilitated by experiences of rejection that he can feel "being" only when acting out hatred, anger, and rage at others.

UNWILLINGLY TO SCHOOL: the place of the child guidance clinic in the treatment of school phobia. Jack H. Kahn, M.D., and Jean P. Nursten. Foreword by Mildred Creak. Published by Pergamon Press, Inc., London, England. Distributed by the Macmillan Co., New York. 1964. 187 pp. \$2.95.

The authors of this book draw on their own experience with neurotic children to discuss the etiology and treatment of the morbid fear some children have of leaving home for school. They identify three aims for doing so: (1) to consider the problem of school phobia in a practical way; (2) to examine the manifestations of disturbed feelings and behavior in a theoretical framework; and (3) to discuss the interprofessional difficulties of dealing with the disturbed behavior that results in school phobia.

The authors point out that the usual truant often comes from a materially and emotionally poor home and that

the child with school phobia often comes from a comfortable home where emotions are intense. The child with school phobia has frequently transferred a conflict from his home problem to the school.

The authors warn against accepting the manifestations of the phobia causes. They describe treatment terms of the separate and joint functions of the professional members of child guidance team—the psychiatrist, the psychologist, and the psychiatric social worker. They also describe conflicts in practices among workers, the various services which deal with the problem of school phobia and recommend a multidisciplinary method attacking the problem.

DEVELOPMENT AND DISORDER OF WRITTEN LANGUAGE, VOLUME I: picture story language to Helmer R. Myklebust. Grune Stratton, New York and London. 1965. 278 pp. \$7.75.

In this first volume of a 2-volume work on the development of and disorders in written language, the author describes the types and origin of various disorders and gives examples of their effects on writing. A large part of the book is given to a description of a picture story language test developed by the author as a "standardized procedure for appraising normal facility in the written word" and a means of studying, diagnosing, and categorizing "disorders of this type of verbal behavior."

In the test the child is shown a picture about which he then writes a story. The results are scored by standards the author has developed for productivity (length of expression), correctness, and meaning. The book describes the administration of the test, directions for scoring, and norms for written language.

The author reports trying out the test on more than 700 schoolchildren ages 7 to 17, in 3 schools. The students were from all socioeconomic levels and cultural backgrounds and from urban, suburban, and rural areas. He found that the results of the test for productivity showed the most stable results. On correction, the results showed rapid growth between ages 7 and 9, slight growth between 9 and 11, and virtually none from 11 on. For meaning, results showed gradual growth. Girls progressed more than boys until age 17.

HERE and THERE



Health care

In mid-March, the Chicago Board of Health became the first recipient of a grant from the Children's Bureau to establish comprehensive health services for children of preschool and school age in areas of high concentration of low-income families. Federal grants to provide not more than 75 percent of the cost of such projects were authorized by the 1965 amendments to the Social Security Act. (See CHILDREN, September-October 1965, page 202.)

With the help of the grant, the board will set up and support what it calls COMPCARE centers to offer complete pediatric and adolescent medical care services to children and youth in low-income areas. Teaching hospitals and medical schools will operate the centers, which will be staffed by physicians, social workers, nurses, dentists, nutritionists, health educators, and other professional health personnel. One principle objective is to organize community facilities already in operation to a comprehensive health service for such children.

Negotiations are under way between the Board of Health and several facilities for the establishment of centers: Children's Memorial Hospital in association with the Northwestern University Medical School; Mount Sinai Hospital in association with the University of Chicago Medical School; and the Bobo Roberts Memorial Hospital of the University of Chicago Medical School. These centers will serve an area with an estimated 177,500 children and young people.

The project will go through developmental phases before it is in permanent operation: the recruiting of core staff members; the drafting of agreements, and the setting up of adminis-

trative procedures; and the completion of negotiations between the Board of Health, universities, and hospitals.

The general supervision of the project is under the city's Commissioner of Health and the director of the State department of health. The chief epidemiologist of the local Board of Health will aid in the administration of the project, assisted by the director of nurses, the chief dental officer, and the director of nutrition of the board.

To get it under way the project's director will use the services of Board of Health staff members now in the federally aided maternity and infant care project, which he also heads. In addition, the project will draw on the assistance of as many local and State health, education, and welfare agencies as possible (Head Start, the Chicago Board of Education, and the State health department, to name a few) in line with the provisions of Public Law 89-97 that health services set up by the law be coordinated with such agencies and their services used as much as possible.

Child welfare research

Five new grants, totaling \$160,919, for child welfare research and demonstration projects have been awarded by the Children's Bureau since the first of the year. They were made to—

- The Lane County Youth Project, Eugene, Oreg.; \$28,165, to develop a comprehensive, electronic data system of collecting, processing, and reporting juvenile court statistics which could be a model for courts and a guideline for the further improvement of local, regional, and national reporting procedures.

- The American University, Graduate

School of Government and Public Administration, Washington, D.C.; \$42,563, to determine costs of child welfare services provided by children's institutions.

- The Council on Social Work Education, New York, N.Y.; \$34,776, to conduct a survey of schools of social work faculty and to develop a plan for research on manpower needs in graduate social work education.

- The Wisconsin State Department of Public Welfare, Madison; \$22,103, to pretest and develop a study on the use of social work manpower in noninstitutional child welfare services by defining major social work tasks and developing functional statements for types of workers; field testing a plan for use of social work manpower; studying problems concerning the needs in social work education; and developing a civil service classification system for child welfare workers.

- The University of Puerto Rico, Social Science Research Center, Program of Research and Training in Criminology, Rio Piedras; \$33,312, to conduct a comparative study of the work of juvenile courts in Puerto Rico with juvenile delinquents as part of an international study of the intake and accomplishments of juvenile courts.

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Many children who have been placed in foster care in New York City could have been kept at home had the right services previously been available to their families, according to a study recently completed by the Community Council of Greater New York in cooperation with the New York City Department of Welfare. The study, which was supported by a grant from the Children's Bureau, focused on 891 children placed in foster care for the first time between May 1 and August 31, 1963, and on the conditions existing in the families—425 in all—during the previous year.

The study found five main reasons why placement was necessary: (1) physical illness, incapacity, or confinement of the person caring for the child (29 percent of the families); (2) emotional problems in the child (17 percent); (3) mental illness of the mother (11 percent); (4) severe abuse or neglect (10 percent); and (5) other family breakdown, including desertion and child abandonment, parental incom-

petence, and child rejection (33 percent).

Nearly half (44 percent) the families were one-parent families, the majority of them headed by the mother. About 38 percent of the total were receiving public assistance at the time of placement.

In nearly half the cases (49 percent), the children were kept in foster care no more than 3 months, 16 percent for less than a week. Emotionally disturbed children, however, were usually in care longer.

To help prevent unnecessary placements, the study recommends the provision of around-the-clock child welfare intake services; the provision of funds for paying relatives and family friends for child care; expansion of family and group day-care services; expansion of and more flexibility in homemaker services; stronger protective services; expansion of community psychiatric services; services to strengthen family life; and closer coordination of public assistance and child welfare services in the New York City Department of Welfare.

To provide better care for children requiring placement, the study recommends: more resources for shelter care; an adequate supply of long-term child placement resources for emotionally disturbed children; and improved means of reporting child neglect and abuse. Communities need better data on child welfare services and on the families and children requiring these services, the study concludes.

Copies of the study report, "Paths To Child Placement: Family Situations Prior to Foster Care," by Shirley Jenkins and Mignon Sauber, are available for \$3.50 each from the Council, 225 Park Avenue South, New York, N.Y., 10003.

For youth

Young people of high school and college age who are from economically and culturally deprived areas in California are participating in local or statewide community improvement programs through a project called "Youth Participation in Community Action." The project is sponsored by the Governor's Advisory Committee on Children and Youth, administered by the California Department of the Youth Authority, and financed by the Office of Economic Opportunity with a one-year training

grant under title II of the Economic Opportunity Act of 1964. In mid-March of this year, 186 young people, 162 of high school and 24 of college age, were at work under the project in various parts of the State.

Through the project, the young people are being assigned in teams of five each, to work and study in public and voluntary agencies on programs to improve social, recreational, and educational resources in the State and local communities. For example, they are helping to organize county youth councils, to establish a neighborhood referral center for teenage employment, to set up a tutorial program for youth, and to design neighborhood self-help projects. In the process they are learning to make surveys of community needs, to serve on local committees with both young people and adults, and to interpret to others the needs of young people from deprived areas. Some of them are also serving on a newly established State Youth Council as well as on regional and local youth councils. In addition to the professional supervision provided on their assignments, the young people are being provided with formal training sessions.

The college-age participants are serving as supervisory aides on a yearly salary of \$1,750. The high school-age participants, called trainees, are paid a minimum of \$1.25 an hour for time in service or training.

AFDC policies

Early in February, the NAACP Legal Defense and Educational Fund, Inc., formally challenged both the legality and constitutionality of the "substitute parent" policies which in some States prevent otherwise eligible families from receiving assistance in the Federal-State program of aid to families with dependent children (AFDC). The challenge was made through a complaint filed with the Secretary of Health, Education, and Welfare against the programs in the States of Arkansas and Georgia, along with a petition for a hearing to determine whether these programs were out of conformity with the requirements of the Social Security Act or for a specific ruling on such policies.

The complaint charges that "substitute parent" policies—which regard a man who has regular social or sexual

relations with a woman as responsible for the support of "any child had that woman" regardless of his ability or willingness to support—are subverting the purposes of the AFDC program by creating a new meaning for the word "parent." It maintains that such policies are serving as devices for carrying on the "suitable homes" criteria for eligibility to AFDC outlay by former Secretary of Health, Education, and Welfare Arthur E. Flemming in a ruling made in 1961 as a result of a hearing on Louisiana AFDC policies. (See CHILDREN, March-April 1961, page 73.)

The complaint also charges that "substitute parent" policies not only violate title IV of the Social Security Act but also flout the constitutional right of all citizens to associate freely with one another, by forcing needy mothers whose husbands are dead or have deserted them "to either abandon the right to privacy and dignity in social relations or to maintain social relations with male friends in a secret and socially destructive manner." It points out that in both Georgia and Arkansas the burden is put on the client to prove that a man she has been seen with not living in her home or having relations with her.

Through their attorneys, two women from Arkansas and two from Georgia joined in filing the complaint and petitions. Three of the women had had similar experiences: Each had been denied aid on the presumption that the man by whom she had had a child but out of wedlock would support the children in her family who were not hers. The fourth woman, a widow active in the civil rights movement, had been continuously threatened with denial of aid if she allowed visiting voter registration workers to stay in her home.

Handicapped children

The Winfield State Hospital, one of three State hospitals in Kansas for mentally retarded, is conducting a study on the use of changed feeding techniques to improve nutritional status of children who are both mentally and physically handicapped. The study is being financed with a \$12,000 grant from the Kansas State Department of Social Welfare.

The study is based on the assumption that some malnutrition in severely

arded children is directly related to the ability to eat enough nourishing food and that the usual methods of feeding the wards may interfere with or impede the development of the child's natural ability to suck, chew, and swallow. Two groups of malnourished, severely retarded children are being studied, each consisting of 12 children to because of neurological damage do not have normal sucking, chewing, and swallowing patterns. One, the experimental group, will live on a controlled ward in which procedures will focus on the provision of intensive therapy in feeding techniques. The other group will live on the regular wards and continue to be fed by normal ward methods. The techniques used with the experimental group will be based on methods developed to stimulate sucking and swallowing. The children will be encouraged to respond to repeated stimuli which include the taste and texture of food, massaging of the lips, and gentle stroking of the cheeks and throat. An integral part of the study is the management of ward procedures in regard to feeding such as the scheduling of the duties of workers and the use of part-time employees at meal hours. will also include work on nutritional problems and specific dietary needs.

Speech and hearing

The use of subprofessional workers in programs for children with speech and hearing handicaps was both criticized and supported by participants in the National Conference on Training in Speech Pathology and Audiology which the Children's Bureau sponsored last January in Washington, D.C. Consequently, participants recommended at the American Speech and Hearing Association undertake a study of the use of manpower in this field to determine which tasks might be performed acceptably by subprofessional workers under professional supervision. The conference brought together representatives of six institutions conducting training supported by the Bureau and six Federal agencies concerned with the training of persons with speech and hearing handicaps.

At a conference in Denver in February, the directors of speech and hearing programs in the health and welfare

departments of the 10 States served by the Dallas and the Denver regional offices of the Children's Bureau discussed, among other topics, the question of requiring hearing-aid dealers to obtain licenses. Participants reached no conclusion on the advisability of setting up this requirement.

Of the States represented, only Oregon now requires licensure for hearing-aid dealers, but several other States are considering legislation to that effect.

Health research

In late March the Children's Bureau awarded 10 grants, totaling \$262,020, for research or study projects in maternal and child health and services for crippled children—7 for new projects, 3 for the continuation of projects begun under previous grants. The grants for new projects were awarded to—

- North Shore Hospital, Manhasset, N.Y., \$28,074, to test for galactosemia (a congenital metabolic disease which usually results in mental retardation) about 15,000 3- to 5-day-old infants in community hospitals.

- Children's Memorial Hospital, Chicago, \$4,500, to determine the incidence and trend of breast feeding in the United States, through a sample study of the extent of the practice among mothers at the time they leave the hospital and comparison of the results with the findings of two previous studies conducted 10 and 20 years ago.

- University of Southern California, Los Angeles, \$14,249, to study the effect of sensorimotor training on the perception and learning of neurologically handicapped children.

- University of North Carolina School of Public Health, Chapel Hill, \$7,776, to determine the nutritional resources available to and the dietary practices of young women during pregnancy who were delivered at two large public hospitals in New York City.

- Temple University School of Medicine and its hospital, Philadelphia, \$17,952, to determine whether methods recommended by health workers for preparing formulas for infants are followed in the home, whether and how they are modified by socioeconomic factors, and whether simpler methods can safely be substituted.

- Northwestern University, Department of Physical Medicine, Evanston, Ill., \$61,071, to set up a workshop to re-

examine methods of therapeutic exercise in order to effect improved curriculums at physical therapy schools.

- University of Kentucky Medical Center, Lexington, \$37,744, to determine the most effective way of operating a care-by-parent in-hospital pediatric unit for chronically ill children from an Appalachian region of Kentucky.

Education

By late March the Department of Health, Education, and Welfare had started proceedings against 80 school districts in 6 Southern States to determine if they are complying with the Civil Rights Act of 1964 and should continue to receive Federal aid. The districts either submitted desegregation plans unacceptable to the U.S. Commissioner of Education or no plans at all. Sixteen of the districts have come into compliance since proceedings began and action against them has been dropped. Federal hearing examiners have handed down initial decisions in 36 cases, all against the continuation of Federal financial assistance. The decisions are being reviewed by the Commissioner of Education, and are subject to review by the Secretary of Health, Education, and Welfare.

The Pennsylvania State University, under contract with the U.S. Office of Education, is preparing a guide for a post-high school program for training workers in the field of child care. A response to the rapidly growing demand from day-care centers, nursery schools, and other facilities for persons trained to assist their professional workers in the care of young children, the guide is intended for use by junior colleges, community colleges, and area vocational schools.

Child welfare services

Federal, State, and local public welfare agencies spent \$352 million for child welfare services in fiscal year 1965, an increase of 12.5 percent over 1964, according to recent estimates of the Children's Bureau. Of the total, 90 percent came from State and local funds. The Federal contribution in 1965 was \$34.2 million, a rise of \$5.4 million over the previous year; the State, \$176 million, a rise of \$20 million; and

the local, \$141.8 million, a rise of \$13.6 million. These figures do not include expenditures by State and local public welfare agencies for operating institutions and group homes for "dependent and neglected children," which in 1965 amounted to \$17.2 million.

The amount spent for child welfare services has risen steadily since fiscal year 1960, when the total was \$211.1 million. The expenditure per child under 21 years old was \$2.93 in 1960; \$4.37 in 1965.

As in the past the largest proportion of the total in 1965 went for foster care: 65 percent. Provision of day-care services took 2.6 percent; personnel costs, 26.6 percent; and educational leave, 0.9 percent. The rest was for miscellaneous expenses.

The provision of services to children in their own homes—including protective services in cases of neglect or abuse and services to unmarried mothers—is one of the numerous recommendations to come out of a study of the Massachusetts public welfare system, made by the National Study Service under the sponsorship of the Massachusetts Committee on Children and Youth and the United Community Services of Metropolitan Boston.

The recommendations call for a complete reorganization of the State's public welfare system through assumption of full administrative and financial responsibility by the State Department of Public Welfare and development of some 50 community service centers through which a broadened and integrated program of services would be operated, including the program of aid to families with dependent children and child welfare services.

The recommendations also call for:

- Integration of the public assistance and general relief categories into a single program based only on need; and the establishment of more nearly adequate budgetary standards for children on assistance.

- Broadening the public agency's adoption services to include children beyond infancy.

- Expansion of homemaker and day-care services to children and the aged.

The Mississippi State Department of Public Welfare, Division of Child Wel-

fare, is presently enlarging its adoption program to provide direct services for all applicants. Until recently, the division referred white infants needing adoption to a voluntary social agency, but no longer does so since the voluntary agency does not meet the requirements of the Civil Rights Act. The division's enlarged service includes service to unmarried mothers, adoptive studies, and placement and supervision of children in adoptive homes. It is now reviewing standards of practice and recruiting additional staff members.

The Nation had about 23,700 licensed or State approved day-care facilities with space for about 310,400 children at the end of September 1965, according to Children's Bureau statistics. Of these facilities, about 7,330 were day-care centers with space for about 252,000 children and 16,370 were family day-care homes with space for about 58,400 children.

Forty-seven States, the District of Columbia, Puerto Rico, and the Virgin Islands include day-care programs in their Federal-State child welfare services plans. Under these plans 7,691 children received day care supported by public funds between July 1 and September 30. On the latter date, 33 States were paying for the day care of 3,253 children enrolled in day-care centers and 22 States, for the day care of 1,329 children in family day-care homes.

Juvenile delinquency

Approximately 686,000 juvenile delinquency cases (excluding traffic offenses) were handled by U.S. juvenile courts in 1964, a 14-percent increase over the previous year as compared to a 4-percent increase in child population, according to estimates of the Children's Bureau based on reports from a national sample of juvenile courts. Because some children were referred more than once, the actual number of children involved was somewhat lower—591,000. Estimates based on these figures indicate that one out of every nine children will be referred to a juvenile court for delinquency (excluding traffic offenses) before age 18.

The reports showed that—

- Four times as many boys as girls were referred to courts for delinquency. The offenses committed by boys and

girls differ. About half the boys but only a sixth of the girls were referred for offenses against property. Girls were referred most often for truancy, running away, and unmanageability.

- The fastest increase was in semi-urban areas.

- One half of the cases were handled by the juvenile courts without a petition being filed (nonjudicially).

- The largest group of offenses for which juveniles were referred in large cities (41 percent) consisted of those committed against property.

These and other facts are contained in "Juvenile Court Statistics—1965" (CB Statistical Series No. 83). Single copies are available from the Bureau without charge.

Miscellaneous

The United Nations Children's Fund (UNICEF) recently granted consultative status to the International Planned Parenthood Federation (IPPF). This means that a representative of IPPF may attend UNICEF Executive Board sessions and may speak on topics of interest to the board and to IPPF. The subject of UNICEF's role in family planning is on the agenda for the UNICEF Executive Board meeting, held in May in Addis Ababa, Ethiopia.

The number of births in 1965 in the United States—3,767,000—represents the smallest number since 1951, according to provisional figures recently released by the U.S. Public Health Service (PHS). The crude birth rate for 1965 was 19.4 per 1,000 persons, close to that recorded in 1938. Despite the drop in numbers, however, the fertility rate (number of births per 1,000 women aged 15-44 years) is well above the 1938 level. In 1965 there were 96.7 births per 1,000 women aged 15-44 as compared with 76 to 79 in the period 1933-39.

Oversight

CHILDREN extends an apology to Dr. Richmond S. Paine, Children's Hospital of the District of Columbia, for failing to give him credit for the photograph of the chromosome karyogram used as the basis for the drawing on page 61 of the March-April 1966 issue.

READERS' EXCHANGE

PAULSEN: *The child is the concern*

When an instance of the brutal abuse of a child bursts upon the community in an undiluted news story, the blood of all responsive people boils. But boiling blood is a notoriously poor solution in which to cook up logic. Thus it is good to see Professor Paulsen treat the issue in a quiet and scholarly manner. ["Legal Protections Against Child Abuse," *Monrad G. Paulsen, CHILDREN, March-April 1966.*]

The greatest need in this area of social work is to be reminded that society's first concern should be for the welfare of the child, leaving retaliation and retribution aside. The Good Samaritan in the Bible did not take off in pursuit of the robbers. He left that task to the sheriff, if there was one in those days. Instead, he took the victim into an inn and arranged for his care. In the same manner, juvenile court judges could spend their energies in mending the child's injuries and taking the steps necessary to insure safe care for the child thereafter—at home if that is possible, or in a substitute home if need be. I tend to agree with The American Humane Association's recommendation that suspected cases be reported to a child welfare agency (where such excesses) rather than to the police. Not that policemen cannot be Good Samaritans, but they more often give priority to the criminal and punitive side of such cases. Protective service agencies are also less likely to inform the press and inflame the community.

Battered child cases, as they have come to be called, although few in number, impose a severe strain on the theory at a community can have a free press and also provide a fair trial. There are good reasons why the reporting states which have been passed so expeditiously in 47 States should provide that such reports be handled in a confidential manner until a court has acquired jurisdiction and made at least a preliminary adjudication. Such a provision

would be protective of the child's safety as well as the right of the parents to a fair hearing. As soon as the newspapers publish the allegations the pressure mounts for quick and drastic action. The opportunity for an impartial social investigation is precluded. Angry letters arrive by the bushel, and the community demands its pound of flesh even before the judicial hearing.

Because most juvenile court judges face such cases only occasionally, I recommend they read Professor Paulsen's article with care and gain some preliminary insight into this special and troublesome area of child neglect cases. Like a home fire, there is seldom time for dispassionate thinking when such a case breaks upon a community.

Orman W. Ketcham

Associate Judge, Juvenile Court of the District of Columbia, and President, National Council of Juvenile Court Judges, Chicago

GARRETT et al: *Families for babies*

Congratulations to *CHILDREN* for the timely emphasis on foster care in the January-February 1966 issue.

Miss Garrett's thoughtful article ["Meeting the Crisis in Foster Family Care," by Beatrice L. Garrett] and Professor Meier's followup study of former foster children ["Adults Who Were Foster Children," by Elizabeth G. Meier] will perhaps encourage agencies to expand long-term, permanent foster-care facilities for children who lack the security of wholesome family life, but for whom adoption is unlikely. The Elizabeth Herzog-Rose Bernstein article—"Why So Few Negro Adoptions?"—in the January-February 1965 issue should be considered as a companion piece to the January-February 1966 articles on foster care.

Among the latter, Aileen B. Ostazeski's report of an experiment in placing children in permanent foster homes ["Preparation for Permanent Foster Care"] coincides to a considerable

degree with the experience of the Spence-Chapin Adoption Service. In September 1962, we undertook a 5-year demonstration project designed to remove well babies from New York City hospital wards and to place in long-term foster family homes those who could not be returned to their natural families and for whom adoption was unlikely. In the ensuing 3½ years, we have served 965 such children, most of them Negro and Puerto Rican. After some casework with their natural parents, 176 of the children could be returned to their own families. Of the others, 143 have been placed in adoption, mainly with their former foster parents. The remainder, 646, are in long-term foster family care; only 50 have had to be transferred from one foster home to another.

Like Mrs. Ostazeski, we have found that: Permanent foster care involves many of the same elements as adoption; the selection of foster parents for specific children is essential; the foster parents must be allowed to act and to feel as though they were the child's natural or adoptive parents; and a "family"-oriented approach with foster parents, concentrating on working with the foster parents' ego strength, is essential.

Social agencies can no longer ignore the imperative need for permanent foster family care for children for whom adoption is unlikely, as it is for so many children of minority groups. As Sterling Tucker once stated in *Child Welfare* [November 1962]: "... the adoption gaps [among Negroes] will be bridged only when the other gaps [in housing, employment, education, and so forth] standing in the way of total family security have been bridged."

Helen B. Montgomery

Executive Director, Spence-Chapin Adoption Service, New York

MALUCCIO: *Supporting foster parents*

I greatly appreciated the article, "Selecting Foster Parents for Disturbed Children," by Anthony N. Maluccio [*CHILDREN*, March-April 1966], but I had to make several assumptions to apply its message to my own experience. I had to assume that there is adequate agency support of the foster parents in the forms of remuneration and casework service (to both foster parents)

as well as growth-producing supports to the foster child at all stages of placement, including special education if needed. I had to assume that the specific family and specific child were matched in relation to their needs so that the experience would be mutually growth-producing.

While I agree with Mr. Maluccio that the ego strengths of the foster parents need to be assayed with particular awareness to the shifting imbalances and stresses of a child in treatment, I find it hard to evaluate these in the abstract. Very few families come to us who could handle the wide variety of personality problems that our children present. In all cases the balancing of individual personality

needs and capacities is of vital import in the selection of a particular family for a particular child. Even when this has been attempted, the agency may need to provide psychotherapy for a member of the family whose equilibrium has been upset by presence of the foster child.

If these commitments are not a basic part of its foster parent program for children, whether or not they are emotionally disturbed, the agency runs the risk of turning away parents who under the right conditions could serve a child well, or the risk of burdening a family to the breaking point.

As an example of this, I would refer to the B family in the article. How much was Mr. B included in the case-

work process while Mrs. B was devoted herself to George's infantile need. Traditionally, casework is provided most exclusively to the foster mother during such a period and too often the result is eventual alienation of the father.

It was most fitting, I felt, if CHILDREN followed the article with quotation addressed to the responsibility of the community to support a foster parent adequately. The reference was to financial support but can be as appropriately interpreted to mean adequate professional development as support.

George E. Go

Casework Director, Children's Study Home, Springfield, Mo.

in the journals

Classes for unmarried mothers

Two articles in *Nursing Outlook* for March 1966 focus on health education for unmarried mothers. ("Health Education Classes for Unwed Mothers" and "Parent Education Groups for Unmarried Mothers.")

In the first, Maralee Burton and Ilverine Holter, both public health nurses on the teaching staff of South Dakota State University, describe a teaching program for unmarried pregnant girls in a residence home for 44. The focus was on health during and immediately after pregnancy. The program used demonstrations of exercises, films, printed matter, and group discussions. The authors found that the girls lacked basic knowledge of anatomy and physiology and that most material on pregnancy is "family-centered."

In the second, Aline B. Auerbach and Mildred Rabinow of the Child Study Association of America report on a session on parent education groups for unmarried mothers in a conference for nurses held in New York City. According to the authors, the nurses concluded that group educational experience for unwed mothers can and should furnish unmarried mothers with opportunity to

learn about the physical aspects of pregnancy, labor, and delivery, and what they will face in providing for the baby, and pointed out that the nurse is in a "particularly favorable position" to help the unmarried mother.

Child welfare staff

Two articles in the March 1966 issue of *Child Welfare* deal with staff needs and the preparation of workers for the child welfare field. ("Education and Training for Child Welfare: A Realistic View," by Elizabeth A. Lawder, and "From the Point of View of the Undergraduate School," by Margaret B. Matson.)

In the first article, Dr. Lawder, executive director of the Children's Aid Society of Pennsylvania, says that, because of the chronic shortage of workers, agencies should clearly define the responsibilities of professional, non-professional, and clerical workers and let community leaders know that they do not have enough workers to provide professional services at all times. She maintains that agencies "cannot let pass for professional competence what is not," and that "only when we make manifest the need for inservice train-

ing, for new patterns of organization and for better collaboration among agencies and schools of social work, we achieve better results."

In the second article, Dr. Matson, director of the social welfare major at the Pennsylvania State University, stresses the importance of undergraduate social work offerings in the recruitment and education of beginners for child welfare field and emphasizes need for closer cooperation between agencies and educational institutions in the provision of such educational opportunities. She particularly stresses the value of agency field placements for undergraduate students and the need for delineating the beginners' tasks.

The young deaf child

Because language develops during early years, the parents of a prenatally school-age deaf child should use the day-to-day contacts with him as much as possible to help him acquire language. Audrey Ann Simmons maintains in the March 1966 issue of *The Voice Review*. ("Language Growth for the Pre-Nursery Deaf Child.") Describing a 6-year "parent-centered" program conducted by the Central Institute for the Deaf in St. Louis, she says that "when parents are given an insight into the problems of deafness and an understanding of the principles of language growth preceding speech development, they can accomplish much with their own children."

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PARENT AND FAMILY LIFE EDUCATION FOR LOW-INCOME FAMILIES: A GUIDE FOR LEADERS. Louise Proehl Shoemaker. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 434. 1965. 66 pp. 30 cents.

This guide grew out of a conference of practitioners in parent education programs which was arranged by the Committee on Parent and Family Education of the Interdepartmental Committee on Children and Youth.

OPTIONS IN 1964. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 8 pp. (Multilithed.) Single copies available from the Bureau without charge.

About 135,000 adoptions were completed in the United States in 1964, according to this report, which presents statistics for 48 States, the District of Columbia, Puerto Rico, and the Virgin Islands, and estimates for 2 nonreporting States. It shows that 53 percent of the children involved were adopted

by nonrelatives; about two-thirds of all adoptions by nonrelatives were arranged by social agencies; about 10 percent of all the children adopted were nonwhite; and about 61 percent (82,400) of the total were born out of wedlock.

SERVICES UNDER AFDC FOR CHILDREN WHO NEED PROTECTION. Claire R. Hancock. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. 1965. 45 pp. 40 cents.

This publication offers guides to public assistance workers on how to help parents with serious problems in child care, how to recognize signs of child neglect, abuse, or rejection, and when and how to make a referral for child welfare services. Appendixes include excerpts from case records and a bibliography.

STATISTICS ON PUBLIC INSTITUTIONS FOR DELINQUENT CHILDREN—1964. Alair A. Townsend. Department of Health, Education, and Welfare, Welfare Administration,

Children's Bureau. CB Statistical Series No. 81. 1965. 39 pp. Single copies available from the Bureau without charge.

Reports information on the number of children in various types of public training schools for delinquent children, numbers committed and discharged, returnee and runaway rates, and institutional costs and personnel, from data provided by 245 of the 274 institutions for juvenile delinquents in the United States (including Puerto Rico and the Virgin Islands).

Findings indicate, among other facts, that: (1) 37 percent of the training schools were overcrowded; (2) 28 percent of the children entering the schools in 1964 had been admitted previously; and (3) nearly a fourth of all employees of the institutions left their jobs in 1964, including 67 percent of the treatment and educational employees.

WHEN YOU ADOPT A CHILD. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 13. 1965. 27 pp. 15 cents.

This revision of a 1958 pamphlet answers some of the questions that should be considered by couples or parents who are planning to adopt a child.

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children

AN INTERDISCIPLINARY JOURNAL FOR
THE PROFESSIONS SERVING CHILDREN

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Effects of Preschool Education

Two Approaches to Family Day Care

Homemaker Services for the Retarded

How Children View Placement



children

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A warm adult-child relationship, as exhibited by this young aide and her three charges in a center for preschool children, may be one key to opening up a child's interest in learning. To provide this and other stimulants to intellectual growth, many "preschool enrichment" experiments are being conducted today. Something of what is known thus far about their effects is described on pages 130 to 134.

some
early
findings
of
research
on

children

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One of the most salient recent educational movements in this country is the widespread development of compensatory programs for culturally deprived children, especially at the preschool level. Project Head Start, sponsored by the Office of Economic Opportunity, alone reached over half a million children in its first year of operation, and thousands of preschool children are enrolled in other programs for the disadvantaged. Although designed primarily to serve educational ends, the value of these programs goes beyond education in a narrow sense. Based on premises about the potential effectiveness of early compensatory intervention as a means of breaking intergenerational cycles of economic and cultural deprivation, the effects of school enrichment programs promise to have important meaning for child-care programs generally. Given their recency and their proliferation, extensive treatment of the subject now would be premature; but a preliminary examination of some of the preschool programs and early findings of research concerning their effects is not untimely.

A basic consideration in the development of compensatory educational programs is the observation by no means recent, that children from poverty-stricken homes tend to do poorly in school. They enter school less well prepared than middle-class children and fall further behind each year. The most effect most often expected from preschool enrichment programs is a change in this tendency, that is, the child's involvement in such a program becomes a means of improving his readiness for school and, in turn, his academic achievement.

The focus on this end does not preclude concern about and provision for other types of outcome; however, the early findings pertain almost exclusively to educational effects. Before examining these findings

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gs, let me mention the rationale underlying the programs and the followup studies which evaluate them.

These programs are shaped largely by assumptions about the characteristics of "culturally deprived" children which underlie their inferior academic performance. These characteristics, which follow patterns of both cognitive and affective deficit—at least from the middle-class point of view—include poor language facility, constriction in dealing with symbolic and abstract ideas, narrowness of outlook because of the narrowness of the familiar environment, passivity and lack of curiosity, low self-esteem, and lack of motivation for achievement.

In developing enrichment programs, the longer range goal of improving academic achievement becomes the proximal goal of modifying these features of the psychological makeup of the "culturally deprived" child; thus, plans for systematic evaluation include both the long-range assessment of school achievement and the assessment of more immediate psychological changes, typically as they are reflected in test scores. Early findings are mainly of the latter type, though this is not exclusively the case.

Early results

Although the preliminary findings concerning the effects of preschool enrichment programs are predominantly positive, this is not universally so. Gains in IQ scores and augmented language-cognitive abilities have been found in several followup studies, along with indirect evidence of greater interest in school and motivation for doing schoolwork. But this is not even true; some followup studies have not found such effects. I will here examine both types of findings.

Two of the earliest programs are the Peabody Early Training Project¹ near Nashville and the program of the Institute for Developmental Studies² directed by Martin Deutsch in New York City. Although the directors of both projects emphasize the importance of long-range followup studies to determine program effectiveness, preliminary results have been reported. From the Peabody project, Gray and Klaus³ report substantial increase in IQ scores, as measured by either the Stanford-Binet or the Wechsler Intelligence Scale for Children (WISC), among children in the program as compared with those of children in control groups. There were gains of 5 and 6 points in two treatment groups and losses of 4 and 6 points in two control groups. Children in treatment groups also had higher scores on the Peabody Picture Vocabulary Test and the Illinois Test of Psycholinguistic Ability, and when they entered the first grade they performed better on reading readiness tests. From the Institute for Developmental Studies, Goldstein² reports comparable differences in Stanford-Binet IQ scores between children attending the experimental preschool program and controls. As in the Peabody project, there were apparently control group losses as well as experimental group gains. Also, as before, the experimental group performed better on the Peabody Picture Vocabulary Test. In both programs, gains in the early experimental groups had been maintained for about 2 years.

From an experimental nursery school program in Philadelphia, Beller⁴ reports similar findings. The children gained about 6 points in Stanford-Binet IQ scores from mid-year in the nursery school to mid-year in kindergarten. Also, at the time of testing in kindergarten, the nursery groups were on the average about 8 points higher in IQ scores than control children with no nursery school experience.

The nursery groups performed better than the control groups on the Peabody Picture Vocabulary Test. A group verbal intelligence test (Philadelphia Verbal Abilities) also reflected the effects of nursery school, but results of an individual nonverbal test (Goodenough Draw-a-Man) showed no consistent difference between the nursery and control groups.

In addition to test scores such as these, there are other indications of the effectiveness of preschool enrichment programs. Weikart, Kamii, and Radin⁴ report from a study in Ypsilanti, Mich., that children who had been in the preschool program had better kindergarten attendance records than the control group children. They were also rated higher by their kindergarten teachers on interest in subject matter, initiative, verbal communication, imagination, and possessiveness toward the teacher.

In the Philadelphia study,³ the nursery school children were rated as more casual, expressive, and flexible than the control group children in reaction to test and learning situations in kindergarten.

Less systematic but interesting impressions were reported in the other preliminary studies I have mentioned. Goldstein² cites statements from parents concerning the positive effects on other children in the family of the child's involvement in the enrichment program of the Institute for Developmental Studies. And Gray and Klaus¹ report indications of effects of their early training project on culturally deprived children not enrolled in it.

There are, in addition, many instances of impressionistic judgment of the good effects of small enrichment programs for which systematic followup is not feasible. Such impressions seem to be universally favorable, in most instances highly so.

But there is another and more cautionary side to the picture. Although there are few studies with negative findings, the results of these studies are too important to be ignored. The most unequivocally negative findings to date, it seems to me, are reported by Alpern⁵ from a program in Indianap-

olis, Ind. He reports that 5-year-old children who attended a preschool program for 7 months made substantial gains on the Metropolitan Reading Test, but so did children in the control group. In both groups, gains were statistically significant, but group differences were not. Both made slight and nonsignificant gains in Stanford-Binet IQ scores. On the bases of these findings, he is strongly skeptical about the value of short-range preschool programs. A followup study 17 months later showed no difference between experimental and control subjects in first grade scores on the Metropolitan Reading Test or in ratings by teachers of academic motivation and progress.

Maintenance of gains

But even when good effects of preschool programs are evident in gains in test scores and observable behavioral changes, are they maintained over extended periods of time? This is a crucial question which can be answered only by long-range followup studies. However, the findings reported by Weikart and others⁴ from the Ypsilanti study are especially significant. At the time of the followup study, the small groups of children had been admitted to prekindergarten program. These groups, together with control groups, were called "waves." Children in wave 0 entered in the fall of 1962 as 4-year-olds and had, at the time of reporting, spent 1 year in the experimental nursery and 1 year in kindergarten. Wave 1 entered in 1962 as 3-year-olds and had spent 2 years in the nursery. Wave 2 children entered in 1963 as 3-year-olds and had spent 1 year in the nursery.

Scores on the Peabody Picture Vocabulary Test, the Illinois Test of Psycholinguistic Ability, Gates Reading Readiness Test, and the Stanford-Binet Intelligence Scale all provided indications of the effects of attending nursery school, but the findings of interest pertain to Stanford-Binet IQ score changes. In all three waves, the experimental and control groups diverged during their first year in the program and at the end of the year group differences were impressive. But for waves 0 and 1, this trend was reversed during the second year. At the end of the second year, the group differences were no longer statistically significant.

Similar findings have been reported by Larson and Olson⁶ from a program in Racine, Wis. At the end of a year in a well-designed kindergarten program, the experimental group performed subst-

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ally better than a comparison group in scores on the Illinois Test of Psycholinguistic Ability. But by the end of the first grade this and other signs of superiority in the children in the experimental group over the children in the control group were no longer evident.

Preliminary findings, however, are not consistent to the extent to which gains from these preschool programs are maintained. As noted above, gains in IQ scores that had already persisted for 2 years were reported from the Peabody project and the Institute for Developmental Studies.

Precisely how we should interpret these initial results is not clear. The extent to which they are regarded optimistically probably would vary from one reader to another. But it seems neither rash nor unduly pessimistic to suppose that the variability they reflect will continue to be evident, even in less preliminary findings. Imperfections in assessment methods would of course be enough to assure variability. But programs of early enrichment differ from one another so extensively they almost assure different results.

Program differences

Getzels⁷ has described these program differences in terms of the different underlying assumptions which the programs reflect about the deficiencies of the culturally deprived child. Present preschool programs for culturally deprived children, he suggests, may fall into these three broad categories:

1. Programs based on the assumption that differences between the culturally deprived child and the middle-class child are matters of degree rather than of kind. Hence, if a given type of nursery program is good for the middle-class child, it is also good for the culturally deprived child. The aim in these programs is to provide supplementary experience.

2. Programs based on the assumption that what culturally deprived children mainly lack is familiarity with school-related objects and activities. The aim here is to provide academic-preparatory preschool experience.

3. Programs based on the assumption that the culturally deprived child differs fundamentally from the middle-class child in self-concept, language, values, and perceptual processes. The aim here is to provide compensatory experience sufficient to modify these environmental effects.



The wonders of the printed page are introduced to two of the children of a Project Head Start preschool center.

As results accumulate, findings should be analyzed in relation to some such typology of programs as Getzels describes. But there are also more simple program differences on which results should probably be examined. They include ages of children at entrance, program duration and amount of time children spend in it, staff characteristics, and the nature and amount of parental involvement in the program.

The interprogram variation in initial ages of the children spans a difference of about 2 years, and the entrance age varies from 3 years in some programs to 5 years in others, but modally the entrance age seems to be 4. In view of what is almost the *raison d'être* of the preschool programs—that is, early intervention is crucial—an examination of results in relation to age differences should be significant.

The programs vary in length from a few weeks or months to several years. They also vary in the amount of time the child spends in the program: from sessions of 2½ or 3 hours a week to sessions of 5 hours for 4 or 5 days a week. Economics indicate the desirability of examining possible relationships between time dimensions and program results.

Two types of program variations in terms of staff characteristics have a bearing: differences in professional training and experience and differences in personal characteristics. With respect to the first, there are several staffing patterns. For example, some programs use both professional and nonprofessional teachers; others use only experienced and certified teachers. Comparative data reported by Beller⁸ are significant here. In one program, all teachers had at least 1 year of experience in teaching culturally deprived children; in two others the staff included

inexperienced teachers. Differences favoring the experimental group were more clearly evident in the first program.

The second type of variation in staffing is represented by the Peabody Early Training Project.¹ All of the children in this program are Negro. In the assignment of staff members, attention was given to balanced representation in sex and color to provide the children with appropriate role models. The consequences for achievement motivation should be particularly significant.

Minimal level of parental involvement is no doubt essential for the success of any program, but there are at least three types of interprogram variation in parental role. Programs differ in (1) the degree of parental commitment prerequisite to the child's enrollment in the program, (2) the level of parental involvement in the educational processes of the program, and (3) the means of enlisting and encouraging parental involvement. It might be valuable to look at these in terms of different effects on the parents as well as on the children. But more than this, such program differences probably make a difference in the types of children served and in attrition rates, both of which are highly important in interpreting different results.

Focus and goals

Careful analyses of programs would undoubtedly reveal other, and perhaps more significant, differences. But whatever the program differences in terms of which results are analyzed, it seems highly important that the ends desired not be narrowly conceived. In this connection, the focus on school readiness and the improvement of academic achievement is not necessarily at the expense of concern about and provision for other types of outcome. In several instances, followup plans call for the assessment of the effect of the program on the child's development in its multiple dimensions. In the Baltimore Early School Admissions Project,⁸ for example, research studies will assess such health and physiological effects as changes in height, weight, and dental and bone development. It will also assess the effect of the program on the child's emotional development and interpersonal behavior. This broad

assessment will increase the relevance of the findings for child-care programs generally.

But even in terms of educational effects per se, it is important that criteria of desirability not be narrowly construed. Findings reported by Kitano may illustrate a crucial issue here. In his study, he found that children who had been enrolled in a child-care center housed in a public school were rated by their teachers in the early elementary grades as well adjusted to school than control children not enrolled in such a program. He suggests that this difference may have been due to the assertiveness of spontaneity nurtured in the permissive atmosphere of the child-care center but not regarded as appropriate in the more highly regimented elementary school classrooms.

This possibility points up the importance of questions raised in Getzels' paper⁷: "Can the standards of today's school be taken safely as the model for the transformation of the culturally deprived child? Is this what we want for our children, or should something else be given as well . . . to the transformation of the school itself?"

¹ Gray, Susan W.; Klaus, R. A.: An experimental preschool program for culturally deprived children. *Child Development*, December 1965.

² Goldstein, L. S.: Evaluation of an enrichment program for socially disadvantaged children (mimeographed). Institute for Developmental Studies, New York Medical College, New York City. June 1965.

³ Beller, E. K.: Annual report of research in the Philadelphia experimental nursery school project (mimeographed). Philadelphia Council for Community Advancement. 1965.

⁴ Weikart, D. P.; Kamii, C. K.; Radin, N. L.: Perry preschool progress report (mimeographed). Ypsilanti Public Schools, Ypsilanti, Mich. June 1964.

⁵ Alpern, G. D.: The failure of a nursery school enrichment program for culturally deprived children. Paper presented at the 1966 meeting of the American Orthopsychiatric Association, San Francisco, California.

⁶ Larson, R. G.; Olson, J. L.: A pilot project for culturally deprived kindergarten children: final report (mimeographed). Unified School District No. 1, Racine, Wis. July 1965.

⁷ Getzels, J. W.: Preschool education. In *Contemporary issues in American education*. Papers prepared for the White House Conference on Education, Washington, D.C. July 1965.

⁸ Baltimore Public Schools: An early school admissions project progress report (mimeographed). Baltimore, Md. 1964.

⁹ Kitano, H. H.: The child-care center: a study of the interaction among one-parent children, parents, and schools. University of California Press, Berkeley. 1964.

a demonstration project corrects its preconceptions through . . .

SOME EFFORTS TO IMPROVE PRIVATE FAMILY DAY CARE

ALICE H. COLLINS

Two years ago the Children's Bureau gave a grant to Friendly House, a community center in Portland, Oreg., to try to develop a new kind of service to improve the quality of day care of children provided directly by one family to another. Called the Day Care Exchange Project, the 3-year project, which is now under the sponsorship of the Portland Community Council, has concentrated on studies of arrangements for family day care already existing in the northwest section of the city and on experimenting with ways of steering families needing day-care services to families likely to provide good child care. Thus far the project has not produced any answers to the important question of how communities can best develop family day care as part of a spectrum of services to children. However, it has modified some preconceptions and raised some new, related questions which may interest others concerned with child welfare.

Northwest Portland is an area where family incomes range from \$1,000 a year to over \$25,000. While chiefly residential, the area includes sections which are becoming industrialized. It contains several hospitals and a mail order house, chiefly employing women.

In 1962, the Portland Community Council sponsored a day-care workshop which underscored the need for increased day-care facilities by families of both middle and low economic levels and the importance of obtaining information on what was now provided as a basis for planning additional services. The need was especially felt at Friendly House, which is not only receiving increasing requests from working and would-be working mothers for help in finding "babysitters," but was also receiving many

inquiries about the possibilities of providing day care from women who wanted to care for other people's children but who did not know how to go about finding the children or whether their homes and child-caring skills were up to the job. Recognizing that a good deal of family day care was already being given, some of it excellent and some not, Friendly House undertook a brief survey of working mothers in northwest Portland, the area it served. It found that many mothers were in need of reliable day-care arrangements and preferred to have them in their own neighborhoods.

Friendly House then drew up a proposal for a project to provide a day-care exchange service to bring together working mothers and day-care mothers who had been selected through a certification program. Under the proposal a small staff of social workers would certify families found suitable to provide day care, conduct an educational program about the service in the community, and provide counseling to parents making use of the exchange. With funds secured from the Children's Bureau, the project got under way on February 1, 1964.

Under the plan, the first year of the project was to be spent on surveying existing private family day-care arrangements in northwest Portland; the next year, on developing a day-care exchange; and the last, on expanding the exchange, if it by then appeared that such a service could improve the quality of family day care for a large number of families at little expense, in terms either of money or of professional time.

Little was known about the families which were already providing day care. The impressions of what they were like ranged from one extreme (the

drunken neglectful neighbor) to another (the wonderful older woman who had been caring for other people's children for many years). In between we envisaged the young mother who cared for her neighbor's child along with her own children—a type we believed would be interested in becoming certified for day care by the projected exchange.

Knowledge about the people who provided family day care, we felt, might provide a basis for setting up standards for certification, since most existing family day-care standards were more concerned with the physical aspects of care than with the elusive characteristics which are sometimes subsumed under the word "warmth." Clues to ways of predicting the quality of care a person could provide without the investment of many hours of casework time would be of value not only for the project, but also for efforts to promote licensing of day-care families.

Moreover, since we saw the future exchange as a service which day-care mothers would join voluntarily, we felt its ability to be helpful to them would depend on an understanding of how they saw their own needs.

The project defines family day care as child care given for more than 10 hours a week in the home of a person unrelated to the child, the child being under 14 and living with his own family. Thus the care might be given at any time within the day's 24 hours. The person giving it we call the day-care mother. However, while "day-care mother" is a useful term for the project, it is not well understood in the community where the familiar "babysitter" is used. We use the terms "natural mother" and "day-care child" for the two other members of what we call "the day-care triangle."

The first survey

Having prepared a list of women known to be giving day care, we proceeded with the survey, which was carried out by experienced social work interviewers. A schedule was designed to yield demographic data and sufficient information about day-care practices in relation to safety, health protection, and child rearing to permit a judgment about quality of care. We also sought information about the attitudes of the day-care mothers toward day care.

The interviewers relied on free discussion, filling out the schedules on their return to the office. Up to three interviews per day-care mother were permitted. Information was thus obtained on a total of 27 day-care mothers.

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We assumed that the quality of day care is high in family homes where—

1. The day-care mother is able to perceive the child as a person having particular social, emotional, a physical needs and capabilities which are related to his level of development and the interaction between himself and his culture.

2. The day-care mother is able to respond to, and meet, the needs of the child.

3. The day-care mother and the natural mother collaborate on behalf of the child in a relationship which is more like a friendship than a strictly business relationship.

We can here give only a brief summary of some of the significant findings of our first survey.

Child care was given at all hours of the day for most of the night, although most of the care provided was for the working day and for 40 to 60 hours a week. Most of the children cared for were of preschool age.

The age range of the day-care mothers was between 20 and 75; a third were under 36. Eighteen finished high school and nine had some college education. Nine were in families with incomes below \$3,000 a year; nine, between \$3,000 and \$5,000; nine, over \$5,000. For three, day care was the family's only source of earned income.

Nearly half the day-care mothers said they had begun to give day care casually—as a favor to a friend or acquaintance. The rest—composed largely of younger mothers—gave financial reasons for beginning the service.

Contrary to our expectations, the majority of day-care mothers had been giving care off and on for at least 5 years, planned to continue, and had fewer children in care than they wanted to have. Two-thirds had not been giving care continuously since they first began. (Similar evidence of un-

se of existing resources in an area of unmet need as found in a study conducted by the Child Welfare League of America.¹)

In the schedule, we had included questions about the natural families of the children in day care, to accomplish two purposes: (1) to learn some facts about these mothers; and (2) to learn whether the day-care mothers had sufficient contact with the natural mothers to know something about the children's family life. We learned that—

- About three-fourths of the natural mothers were employed in "white-collar" jobs, and the rest in "blue-collar" jobs. Nearly three-fourths of the natural mothers were married; the rest were divorced.

- Twenty-six percent of the natural mothers lived within the same block as the day-care mothers, 59 percent lived within 8 blocks of the day-care mother, and 15 percent lived within 1 mile.

Quality of care

Since one of our major objectives was to learn what factors related to quality of care, we developed a set of 13 dimensions for measuring quality. Then two trained social work interviewers independently used each of these dimensions to rank the day-care mother according to the quality of their care. They arrived at similar results. The day-care mothers were then classified into three numerically equal groups in relation to quality of care: high; medium; and low. Cross tabulations were made with the other variables. One of the most significant findings was that 75 percent of the day-care mothers who ranked highest in quality of care had intact families of their own, 60 percent of their children of school age, and were above the poverty level economically.

The interviews offered much less opportunity than had been expected for observing the interaction between the day-care mother and day-care child, chiefly because the day-care mothers had arranged the appointments for a time when the children would be asleep or for other reasons were not present at the interview. However, the interviews produced much more useful information.

For example, nearly all the women initially denied being day-care mothers. Some of this denial, but far from all, could have been attributed to the unfamiliar situation. Some day-care mothers "forgot" about the day-care they were caring for, "remembering" them only toward the end of the interview or even later on seeing the interviewer on the street or at Friendly

House. On the other hand, the day-care mothers were more than willing to talk about day care as a service and readily responded to the interviewer's explanation of need for their help in understanding what was being provided. Eventually, they talked very freely; some even told about breaking the law. One woman said she was caring for 13 infants and thus knowingly violating the group-care licensing law; two women who were recipients of public assistance said they had never reported their day-care earnings.

One of the most troubling findings suggested by these interviews was the high degree of discontinuity in care to which children were being subjected. Children, it became evident, were being moved from one day-care mother to another, to relative's care at home, to another day-care mother, to part-time care by older brothers or sisters, to caring for themselves, and round again.

The case interviews generally gave the impression that the relationship between the day-care mother and the natural mother might be of crucial importance both to the quality and the continuity of care the children received. While few day-care mothers reported actual incidents of difficulty with a child's own mother, many gave evidence of having a great deal of emotional investment in the relationship, either negative or positive. Some, after saying everything was "fine" now, talked feelingly about mothers of children they had cared for in the past.

Some surprises

Because we had planned to use small group discussions, lectures, and television programs as methods for improving the quality of existing family day care in the program of the projected exchange, we decided at the beginning of the project's second phase to try these methods out with the day-care mothers we had surveyed.

We were dismayed to find that, in spite of excellent leadership, the provision of coffee and cookies, and the use of every available publicity resource, the discussion groups drew an average of only five persons at each meeting. Those who attended were, with one exception, members of the Friendly House Mothers' Club which had been in existence for 4 years. They included women from each of the quality-of-care ranking groups.

Although discussion was free in all the meetings, the statements about day care were chiefly concerned with the importance of safety, knowing addresses and

telephone numbers of the natural mothers, and "giving security" to children. The women tended to talk interchangeably as day-care mothers and natural mothers since they were both.

In studying the possibility of preparing television programs on family day care, we had another experience contrary to our expectations. A leading television producer in the community was ready to develop some programs with us, but we found we knew so little about the "pressure points" in the day-care mothers' task, the daily routines, and the interaction of the members of the day-care triangle that we did not have enough fresh, meaningful material on which to base a series of educational TV programs. Reluctantly, we postponed the development of the series until we should have a better idea of the audience to be reached and the messages that ought to be conveyed.

At the end of the first 14 months of the project, we were face to face with some unsettling findings. First of all, it appeared that the day-care mothers who ranked highest on quality of care—the type we wanted to attract to the exchange—had children of their own and would be unlikely to participate in group discussions that would take them away from home. It seemed likely, too, that their concern for their own children meant that they would provide day care for other children only when nothing at home made it difficult. The day-care mother's own family difficulties were revealed as one possible source of discontinuity in the day care of children which an exchange could not alter.

Moreover, it seemed unlikely that a central exchange could meet the demands of emergencies—illness, job and hour changes, presence or absence of relatives in both the day-care and natural family—which would require a constantly changing roster of day-care mothers certified for care. Nor could we think of anything we could offer that would induce "good" day-care mothers to join the exchange. We could not assure the best day-care mothers a higher fee as an inducement toward becoming certified members of the exchange since financial supplementation was not part of our plan.

Yet another aspect of the exchange, as originally conceived, began to trouble us. The least adequate day-care mothers had appeared to the social work interviewers to be those who needed to care for other people's children because of deep personal deprivation, either emotional or financial, and so were the most likely to wish to join and use an exchange. However, such day-care mothers would not be able

to qualify for certification without a long period of individual help. The exchange could not offer such help without taking on a much larger professional staff than had been planned.

We conjectured that exclusion from a day-care exchange would no more interfere with the provision of day care by inadequate day-care mothers than existing agency regulations were preventing. We also feared that exclusion might be regarded only another rejection by women whose inadequacies stemmed from their own past deprivations and might alienate them from Friendly House, thus cutting them off from badly needed help.

Still another facet of our experience made question the value of organizing the exchange as originally conceived. This was our observation that day-care triangles were constantly forming, dissolving, and reforming without outside intervention. Times calls that came to us were usually for help in emergency when a grandmother or customary day-care mother was unable to care for a child and a natural mother had to go to work "right away." On such occasions, we phoned one or two of the highest ranking day-care mothers in our study sample. Often the woman we phoned offered to find a friend to care for the child and did so, thus reinforcing our belief that a day-care system was already operating in the community.

However, we felt more strongly than ever that an exchange was needed: to provide for the en-

A family day-care mother in Portland greets a child as she arrives with her mother, along with some spare clothes.



encies and changes in day-care arrangements; to permit continuing observation of the quality of the care children were getting; to advise women who were considering going to work about the kind of care available; to develop and maintain opportunities for good family day care to cover a variety of needs—before and after school, evenings and all night, the hours between parental work shifts, or substitute day care for a child who is sick and so unwelcome in his usual day-care home. We believed a day-care exchange could be of service to both the givers and receivers of family day care because of the endlessly changing circumstances which affect the day-care supply and demand—seasonal work, the effort toward home ownership, the need and desire for more education for family members, changing work hours, pregnancy, divorce.

The new exchange plan

Clinical evidence has underscored the importance of continuity of environment for children who are separated from their mothers. Knowing this, we felt that being cared for within the immediate neighborhood of his own home, where there is continuity of surroundings and playmates and probably also of child-rearing practices, might compensate a child in part for whatever discontinuity in caretakers he has subjected to. It seemed to us that a family day-care exchange would work best if it were decentralized into the neighborhoods and social workers in a central office acted as consultants to neighborhood exchange agents. We believe we could identify persons with potential for being such agents, Day-Care Neighbors among the women in our surveyed population. The prototype would be the woman in a large, extended family to whom the others turned in times of stress or to “just talk.”

We therefore modified the plan for the exchange accordingly, but before establishing the neighborhood service we undertook some further studies.

We wanted to learn more about how much discontinuity there was in day care and under what conditions it occurred. We wanted, too, to learn more about the complexity and importance of the relationship between the day-care mother and the natural mother and its connection with continuity of care. We believed that if we were to help the new Day-Care Neighbors bring about improvement in the quality of the interaction between the members of a day-care triangle, we needed to know as much as we could about this interaction ourselves.

Therefore, in the summer of 1965, we undertook a second survey of our original study population, drawing on the project's experience for a baseline for questions about quantity and continuity of care. Only 22 of the original 27 day-care mothers were reinterviewed, as 5 were no longer available for interviews. The participants readily received the interviewers and often amazed them by recalling almost verbatim what they had said the year before, a consequence of casework interviewing in the first survey predicted by our consultant, Christophe M. Heinicke.

In regard to continuity of care, the second survey showed that during the year:

- Twenty of the day-care mothers had cared for a total of 114 children of 79 natural mothers; and of these, 6 had cared for some of the same children as in the previous year, 6 had cared for only 1 child, 5 had cared for 10 or more children. Two of the former day-care mothers had not given any care and did not expect to do so in the future.

- Of the 114 children who received care, almost half had been in the same day-care home less than 6 months; 15 percent had been in the same day-care home for less than 1 month. The children who had been in the respondents' care for the shortest time had been in other nonrelative day care previously. Those who had been in the respondents' care for more than 1 year had previously been cared for at home by their mothers.

In regard to relationships within the day-care triangle, the new study indicated that:

- The natural mothers of the children in care for the shortest time did not maintain contact with the day-care mother after the day care was terminated, nor did the children. The natural mothers of the children in continuous care for more than a year maintained a friendly relationship with the day-care mother afterward, as did the children.

- The children in care for the shortest periods of time were children who required care for more than 50 hours a week because their mothers had to support themselves.

- The termination of the day-care relationship had been instigated by the natural mothers four times as often as by the day-care mothers. The relationship between the day-care mother and natural mother was businesslike where care was shortest and more friendly where care was longest.

Among other studies undertaken was a utilization study through which we attempted to compare the continuity of care and characteristics of the natural mothers in our surveyed population with the same factors in the clientele of three day nurseries and one social agency conducted family day-care service. There seemed to be little difference between users of the two types of services, but the data were not sufficiently comparable to permit satisfactory conclusions.

Since our projected Day-Care Neighbor Service was planned to function in neighborhoods of differing socioeconomic and demographic characteristics and to make use of "neighborliness" (whose very existence has been questioned in some social science literature), we wanted to learn something about possible differences in attitudes and practices that might exist in different neighborhoods. Therefore we carried out a small survey, with a short schedule of questions, of 25 contiguous households in each of 4 different census tracts having different characteristics, particularly in proportions of married women with children, older women, working women, and age of children. Experience had taught us to avoid the use of the word "day care" and of questions which could be interpreted as soliciting people to provide care, so we asked about child-care practices in general, about "neighbors," and about attitudes toward working women.

Over the years, one of the frustrating features of the day-care field has been the lack of interest in day care by the public at large as well as by professional social workers. The neighborhood study gave evidence of this. In general, the respondents, regardless of the neighborhood they lived in, said that they knew very little about babysitting, and then contradicted this statement by adding that people did not formerly use babysitters as much as they do now and then describing their own babysitting customs.

More than 90 percent of all those questioned said mothers should not work unless they "have to." Most of the respondents in three of the census tracts said they thought that the women in their neighborhoods who worked did so because they had to. But about two-fifths of the respondents in the census tract of the lowest socioeconomic level said they thought the women in their neighborhoods worked to earn "extras" because they were bored.

In the census tract of the lowest socioeconomic level, four-fifths of the respondents said they believed

that "neighbors don't know each other as well as they used to," but only half of the respondents in the highest socioeconomic neighborhood believed this. Twice as many of those in the highest socioeconomic neighborhood as those in the lowest knew what the neighbors did for a living and twice as many in the former group had visited in their neighbors' homes in the past 3 months. Most of the respondents in the highest socioeconomic area said that if they needed a babysitter, they would find one through their neighbors; in contrast, the respondents in the lowest socioeconomic area said they would seek one through the newspaper or an agency.

Day-Care Neighbor Service

After a 4-month pilot program with two Day-Care Neighbors who helped us plan and organize the projected service, we officially opened the Day-Care Neighbor Service on February 1, 1966. The service objectives are: (1) to increase the amount of good private family day care for children; (2) to provide information about the operation of the existing day care system; (3) to develop social work methods and adapt existing methods to reach these goals.

While it is obviously too soon to report on the service, we know that women who themselves provide good day care can be recruited to serve as Day-Care Neighbors for we already have the full complement of six provided for in our budget. Although the women have a variety of socioeconomic backgrounds, each has agreed to our fee of \$25 a month. We do not see their role as being "semiprofessional," but rather as making the most of their existing position in the neighborhood and in the day-care system.

Our experience with the pilot project has led us to believe that, with social work consultation, these Day-Care Neighbors can function effectively in the day-care system. There is no doubt that they can greatly increase our understanding of the operation of this complicated system. At present, this appears to include even a greater degree of discontinuity of care than even our resurvey suggested.

Through this Day-Care Neighbor Service, we hope eventually to find ways of dealing with the core problems in the day-care triangle as they affect the children.

¹ Child Welfare League of America: Day care and related facilities. New York. January 1965. (Mimeographed.)

a public child welfare
agency's experience
in developing . . .

FAMILY DAY CARE FOR CHILDREN

FRANK A. FOLEY

In 4 years of operating a family day-care service as part of its public child welfare program, the Division of Child Welfare of the Monroe County (N.Y.) Department of Social Welfare has learned considerably more about the value of the need for a family day-care service in the community and the vicissitudes of getting such a service under way than it did at the outset. Originally begun as a service for mothers in the public assistance program, the service is now offered, on a case-work determination of social need, to families throughout the community.

With the industrial city of Rochester as its core, Monroe County has a population of about 500,000, about one-tenth is nonwhite. Employment is relatively stable. The median income for all families is \$7,000; but 10 percent of the families have incomes under \$3,000 and 1.5 percent are receiving public assistance.

In our community, interest in the need for a service to provide day care for children in family settings originated with the Monroe County Council of Social Agencies, the coordinating body for the community's 9 public and voluntary health and welfare agencies—including two Community Chest supported day-care centers. During the 1950's, the council's

Family and Children's Division—representative of 35 casework agencies—had frequently discussed the need for such a service for children for whom group care in a day-care center was not advisable but whose family situation required that they be cared for away from home during the day. The chief concern was for children from families in which the social situation—interpersonal conflicts, illness, or the strain on an overburdened mother—indicated that separation of child and mother during the day might be necessary as a step toward strengthening family life. In the fall of 1961, the council's newly formed Day Care Committee conducted a sample survey among local family service agencies—including the county welfare department's public assistance division—to determine the volume of such need.

The agencies were asked to list families who, in a given period, had been asking for help in making a day-care arrangement for a child or children, and another list of families for whom the caseworker would have chosen family day care if this service had been available, and the reasons why. The replies were startling. Caseworkers in the county welfare department's public assistance division alone reported 450 families who in their judgment could have beneficially used a family day-care service. The two community day-care centers, which had carried out the survey for the council, considered developing family day care as an adjunct to their group-care services, but did not have the funds to do so without additional Community Chest support, and this was not forthcoming.

At that time the county welfare department had no legal authority under State law to provide a day-care service or to use State child welfare services funds for the purpose. However, the imminent provision of Federal funds for day care appeared on the horizon with the introduction of the 1962 Public Welfare Amendments to the Social Security Act,¹ and a change in the New York State Social Welfare Law became a distinct possibility. Therefore, the State Department of Social Welfare encouraged the local welfare departments to plan to provide day-care services. In Monroe County we found that with cooperation between our public assistance and child welfare divisions, we could, with appropriate participation of the State Bureau of Child Welfare, get some family day-care service under way under existing State law and even before the Federal funds, appropriated in 1963, became available.

The plan was for the public assistance program, which already allowed an item for group day care to

be included in the budgets of recipient families needing this service, also to allow the inclusion of an item for the day care of children in families approved as day-care providers by the State Bureau of Child Welfare. Family day-care homes would be recruited and studied by the staff of the local child welfare services program and those found promising referred to the area office of the State Bureau of Child Welfare where responsibility for approving or disapproving the home would rest. The final decision would be made after a member of the State child welfare staff had visited the home.

Our initial program was, therefore, confined to providing service to families in the public assistance program. In the beginning it was limited to those who were living in the two census tracts where the council's survey had indicated the need for day care was greatest.

Before we got under way, we had some difficult planning sessions because of differing points of view between our public assistance and child welfare divisions on how the day-care families should be paid for their services. The public assistance division fought hard for adhering to its principle of including funds for all supplies and services budgeted for a family in a direct cash payment to the family head, who is then responsible for paying the vendor himself. The child welfare representatives held firm to the principle that families approved by the agency to provide care to other people's children—whether full-time foster care or day care—should be paid directly by the agency, since the foster mother or day-care mother works under standards and policies set by the agency and not by the child's parents. In the end the point of view of the child welfare representatives prevailed and a system for authorizing direct vendor payments was devised.

Getting under way

On July 1, 1962, Family Day-Care Service became an established unit within the child welfare division of the Monroe County Department of Social Welfare. It was staffed by an experienced child welfare supervisor with full graduate training. In the early months of the program she handled all its aspects alone.

Initially, the supervisor spent most of her time publicizing the agency's need for family day-care homes and recruiting families to provide daytime child care. She prepared a fact sheet which she distributed widely among groups of social workers,

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nurses, doctors, clergymen, and laymen, including women's clubs, boards and staffs of character building agencies, and professional organizations. She also began a reference library on day care for use by professional staff members and prospective day-care mothers.

Before long the supervisor became very busy handling inquiries and applications from prospective day-care mothers. But referrals of families for service trickled in slowly.

The first referrals were almost all for the care of Negro children. Just as the agency had always had difficulty in developing boarding and adoption homes for Negro children, so it found difficulty in locating family day-care homes. It had established a rule that every day-care home must be within walking distance of the child's own home. This presented real difficulty since these children lived in the city's most blighted areas.

The day-care supervisor involved all sorts of people in homefinding—school, church, housing authority, and settlement personnel—and finally succeeded in securing family day-care homes for Negro children. Then came the surprise. She discovered that the families for whom she had been making the plans had not waited for the agency but had found jobs and had taken themselves off the assistance rolls. Since at that time the family day-care service could only be offered to public assistance recipients, the agency could not offer these families the supervised day-care homes that had been found for them.

Another surprise was the scarcity of referrals from the public assistance division. However, this gave the day-care supervisor an opportunity to make thorough studies of each family referred for service and of the prospective day-care home. Then came another frustrating surprise. Many of the families who were referred for the family day-care service did not want it! In many instances the family public assistance worker, noting inadequacies in the care provided a child in his own home, had apparently thought of day care as a panacea for his prob-

ms. Moreover, while referrals for day care had not been made simply to get the mother into the labor market, some of the mothers thought they were. And indeed some of the referrals could have resulted in helping the mother to provide better child care, but in her abrogation of her child-care responsibilities.

In interviewing many of the mothers referred for the service, the family day-care supervisor found them tense and suspicious. Some of them seemed to think the agency was trying to get their children away from them. When they learned that the service was available only to assistance recipients, they saw it as something not quite respectable.

Another surprise, however, was more encouraging. Some highly disorganized parents who had very damaging relationships with their children but who had resisted suggestions for their placement in foster care accepted the offer of family day care. In some instances this proved to be a successful step toward badly needed full-time separation of parent and child. In other instances, however, the mother lacked sufficient strength to get the child up and dressed and to the family day-care home, although it was in her own neighborhood.

Because so few suitable referrals were made by the public assistance workers covering the two census tracts to which the service was initially restricted, the service was soon opened to assistance recipients throughout the county. Still very few referrals were made.

The discrepancy between what the day-care survey had led us to expect and the number of referrals received obviously arose from the realization of public assistance workers, after the program got under way, that some of the families they had originally thought would benefit from day care were either not able or not ready to use such a service. It became clear that a great deal of casework was necessary to help families benefit from it.

Types of families served

In December 1963, Federal funds for day care became available for the service through the State Department of Social Welfare. We were therefore able to enlarge the day-care staff with the addition of two caseworkers and to extend the service to families needing it, whether or not they were on the assistance rolls. Soon the unit was serving many mothers whose motivation for employment was high but was accompanied by considerable pathology in family

relationships. At present the family day-care caseworkers handle intake, homefinding, supervision of the day-care home, and, except in some cases already being served by other child welfare workers, continuing casework with the child's own parents.

Today the families who come to the unit for placement of their children in family day care can, for the most part, be classified into three groups:

1. Young families in which the father is a graduate student in one of the local institutions for higher learning and the mother, the main breadwinner. For example:

The A's are young parents of a 4-year-old child who are expecting a new baby in a few months. Mr. A is one of several graduate students who have sought family day-care service. Mrs. A is employed as a clerical worker and supports the family. In spite of the fact that these young people did not plan to have children until the husband finished his schooling and that they are deeply in debt and have some difficulties with their own parents, they discuss their problems in a matter-of-fact way and do not express feelings of anxiety about them or about the new baby. Although their 4-year-old little girl has been cared for by numerous substitute mothers since her birth, she is making a good adjustment in the family day-care home provided by the service.

2. Families of divorced parents in which the employed mother carries full responsibility for rearing the children. For example:

Mrs. B is an attractive, intelligent, warm, and stable 32-year-old mother of two children ages 8 and 2. She experienced a very stormy marriage with an immature husband who acted out his hostilities in a flagrant manner. Both she and the children bear emotional scars. Even now Mr. B uses his visiting privileges with the children to punish their mother by trying to turn their affections from her.

Mrs. B and the children now live with Mrs. B's parents, who are both employed and who complain that the children make them nervous. Mrs. B's 8-year-old daughter has exhibited some reactive behavior, anxiety, and poor school adjustment, but has improved since settling into family day care. Mrs. B uses her relationship with the caseworker to ventilate her feelings and to plan for her own and the children's adjustment to life with the grandparents, the family day-care mother, and Mr. B's continuing and disturbing visits.

3. Families with rather severe social malfunctioning. For example:

The C's are young 24-year-old parents of a 6-month-old child. Both parents have extremely dependent personalities and have great difficulty in expressing their feelings. Mrs. C uses the baby to hold off her husband's attention. Mr. C acts out his inner stress through excessive activity and busy work. When they applied for family day care for their child, the C's were nearly overwhelmed by financial stress. They reacted to

this by further constricting their feelings and by seeking employment for Mrs. C.

In the casework interviews Mr. C was initially hostile, but now pours out his troubles with apparent relief. Mrs. C, on the other hand, strictly controls her feelings and has a very flip attitude toward the caseworker. The baby reflects the family strain by extreme tenseness, constant crying, and demands for attention in the day-care family, as well as by the physical symptoms of allergy and diarrhea.

We also serve families who come to us because they want to "park" their children so that the mother can go to work to bring the family a second salary. We believe that such families need our service, but in offering it to them we ask the parents to involve themselves in goal-directed planning.

In all cases the agency provides casework help to the family not only at the point of admission to the service, but also on a regular basis during the entire time the child is in care.

The caseworkers in the service also provide support to the day-care mothers to help them to understand and withstand the behavior of children who are reacting to problems in their own families and to the daily separation from their parents. We hope to experiment in the future with group meetings for training day-care parents.

Problems and promise

In short, in our 4 years of experience in establishing and operating a family day-care service we have encountered problems requiring difficult policy decisions in four areas:

1. **Administrative procedures regarding certification of day-care homes and methods of payment.** Although the methods we adopted were difficult to work out, they are now operating smoothly.

2. **Recruitment and training of day-care families.** We have stuck by our decision to place children in the same neighborhood in which they live, although this has added to our recruitment difficulties.

3. **Intake.** While we see the family day-care placement as part of a total family casework service, we have had difficulty arriving at a sharp definition of intake policy. In other words, the questions still arise: Should we limit our services to families requesting casework service because of malfunctioning in the family? Or should we also serve parents who

resist casework help and wish only to be provided with a reliable day-care home for their children?

4. **The use of the agency's casework staff.** Because of the chronic shortage of professional social caseworkers in a public agency, the question also arises about how much casework treatment the family day-care service should provide. In other words, when the agency receives a request for day care from a family in which there is serious pathology, should the child be placed in family day care and the parent referred to the voluntary family service agency for casework help? Or should the casework treatment be provided by the public agency's family day-care caseworker? We believe that sound practice requires the second alternative for we see the day-care placement as an integral part of a total casework service. However, shortage of professional caseworkers in the public agency makes this level of service difficult to provide. The goal will probably not be fully achieved until the public agency has staff requirements and salary levels high enough to attract and retain more highly skilled personnel.

In spite of these difficulties we are convinced that the family day-care service is an important addition to our public child welfare program's efforts to strengthen family life. Today we have 27 children from 20 families in family day-care homes, and children awaiting placement. Those in care range in age from 2 months to 12 years, but the majority are under 5 years of age.

All are children who need the service either because being away from their families during the day is a therapeutic necessity, or because their mothers are determined to go to work and without our provision of a supervised day-care family would likely to fall back on a hit-or-miss, and hence, hazardous child-care arrangement.

Our experience has convinced us that a public agency is performing a real service to children when it sets up a family day-care program, *if* it accepts children for family day care only if this is the best plan that can be made for them, and *if* the agency is able to provide skilled social caseworkers for recruiting and sustaining day-care homes and for working with families to remedy many of the situations which make the day care necessary.

¹ Public Law 87-543.

A NURSERY SCHOOL IN A REHABILITATION CENTER

For the past 4 years, the Institute of Physical Medicine and Rehabilitation, New York University Medical Center, has operated a school for preschool-age children admitted to the hospital as inpatients for diagnostic evaluation or therapy, or both. An integral part of the institute since 1965, the school grew out of a 1-year experiment to create a "caring situation" for children. It has our main responsibilities:

1. To stimulate the intellectual, social, and emotional growth of the children it serves.
2. To provide the institute's staff—physicians, psychologists, social workers, nurses, and speech, physical, and occupational therapists—with an opportunity for acquiring realistic ideas of how the young child's adaptive and cognitive powers function.
3. To compare the responses of handicapped preschool children with those of normal children.
4. To evaluate learning disabilities in handicapped preschool children and to initiate therapeutic measures in the preschool period.

When we began to set up the nursery school as charged, the educational consultant, Jessie Stanton, and I were uncertain about how we would have to modify educational procedures, methods, and materials to fit the school into a medical framework. We did know, however, that each child's program would have to fit in with his appointments for therapy and that each program would have to be noncontinuous and different. We also questioned the possibility of effectively serving a constantly changing class of children of varying chronological and mental ages,

endowment, and experience whose development was impaired or interrupted in many ways. The pathological and physical disabilities of the children range from minor to severe; the level of their intelligence, from grossly defective to superior.

The school, which began in the children's dining room, will have its own especially designed quarters as a "laboratory for the study of learning dysfunction" in the institute's new research wing because the medical staff has found its program valuable. From our experience, we believe that the program has also been of value to the children and that any success is based on flexible and sensitive planning for the entire program and for each child's program.

Interdisciplinary coordination

Coordinating our work with that of other disciplines is an important part of the program. This begins on admission, at the time the child and his parents are seen by the resident doctor, the social worker assigned to the case, nurses, and administrators. If the child is of nursery-school age, his parents are asked to bring him into the school. Whenever possible, I, as director, talk with the mother to learn what I can about the child's home-play pattern, favorite materials, and special interest, and to observe signs of the quality of the parent-child relationship.

The social worker, who is in the best position to have a full view of the child as a member of a family and a community, tells the nursery school staff what she has learned about the child's needs and the parents' desires and expectations for him. The nursery school staff also works with the social service department, when requested, to find the best educational

resource in the community for the child. When the child is discharged from the institute, a summary of his progress in the school and recommendations for further schooling are attached to the final report sent to the school or training center to which he is referred.

The nursery school's relationship with the center's occupational, physical, and speech therapists is functional; that is, it reinforces the therapist's "teaching" by incorporating his goals into play situations.

About 4 days after admission to the institute, members of each professional staff meet to report on the child's developmental status. After these evaluations, each child is assigned to an individual program of half-hour periods of therapy. One child's program may call for three periods of paramedical therapy every morning—one each in speech, occupational, and physical therapy—and 1 hour or 2 half-hour periods for educational therapy. Another's program may call for only a half-hour of physical therapy, and 2 hours for school. A child will follow this program until discharge (the average stay is 6 weeks).

The physiatrist makes specific recommendations for nursery school attendance similar to those made for medical therapy or speech training.

At weekly staff meetings thereafter, the nursery school director, using the normal child as reference, appraises the patient's progress and on the basis of this report the school's staff draws up educational plans for him.

The nursery school operates on the theory that the hospitalized, handicapped child can be helped to grow emotionally and intellectually in a warm and stimulating environment in which he is free to express his feelings and which offers him opportunities to accomplish and to experience pleasure and success. Therefore, we are trying to give the children:

• *An opportunity to use materials* from which they may derive satisfaction, enjoyment, and feelings of

mastery. They are offered: (a) sensory experience with water, play dough, clay and plastiscene, and finger paints; (b) creative art activities with a variety of art media; (c) experience with blocks, puzzles, and manipulative toys to help them develop ideas of space and organization; (d) an opportunity through dramatic play in a housekeeping corner, to relive and recreate home and hospital experience and to release feelings about these experiences; and (e) an introduction to the physical world through simple experiments with water pressures and levels, magnetism, and flotation.

• *Encouragement in the use of expressive language* as a means of communication.

• *Exposure to music and literature* stimulating and meaningful at their age.

• *An opportunity to be with other children*—to learn the gratification of being part of a group and the controls required of a group member.

The nursery school staff consists of a teacher director, a teacher, and one assistant. Although there are usually 15 children in the preschool program on any 1 day, each half-hour session involves no more than 6 children.

The curriculum followed and the materials selected each day are influenced by weekly admission changes; the composition of the class at any half-hour period is arranged as meticulously as possible to afford each child an optimum working environment with other children at his level. The temporary composition of each session makes flexibility in program imperative as do the variations in the children's neurological and physical status, chronological ages (2-8), and mental ages (1-5). When a child needs a one-to-one relationship with the teacher, his need is met. If he cannot benefit from group experience or if he disrupts the group, a tutorial method is used in a corner of the room, free from distraction.

When a teacher tries to educate a child rather than just to teach a subject to him, she has no standard methods or technique to elicit optimum response from different children. This problem is magnified in our nursery school because the differences in functioning are influenced by the children's pathology. A teacher of abnormal children must first know normal children well to recognize the effects of the child's defect on his ability to perform. She has to understand what he has in common with normal children and how to build on this in his program. This enables her to find the elements of a maximal learning

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environment for each child by using new methods, improvising materials, and experimenting.

Understanding the organized information each child brings with him is a demanding and difficult task for the teacher. Yet on her understanding hinges many decisions concerning adaptations in technique, methodology, and curriculum.

Experience has shown that a teaching method used successfully with a child suffering from muscular atrophy is not successful with a child suffering from cerebral injury and that a teaching method successful with a mentally retarded child may not be successful with a brain-injured child whose retardation is only spotty.

We try as much as possible to concentrate on the area of his disability, not just to encourage him, as an emotional compensation for his disability, to excel in areas in which he is well-endowed. Many children in our nursery school have perceptual deficits which interfere with their ability to determine relationships between things and high and inappropriate levels of distractibility. Such children lose track of the task at hand because they become overly involved with detail, and do not see the goal. They seldom evaluate situations correctly and make inappropriate and socially unacceptable responses.

We find that when given a typical wooden preschool puzzle, a child with this type of brain injury is frequently content to turn the plaque over and empty the puzzle of its pieces. If he goes further, he tries to select the correct piece only on the basis of color or a detail, or a tenuous understanding of the relationship of the part to the whole. He does not integrate detail and the whole, and uses tactile clues without visual aids. He often places pegs in a board by touch only. Therefore, the teacher tries constantly to help him integrate the clues of all the senses. To do so she must add more details to the task. For example, with a peg board, she may add a color sequence to follow and a pattern to imitate.

Use of materials

Despite the need to make many adaptations for our children, perhaps the most revealing experience of the school has been the reinforcement of our confidence in good, well-selected, and well-presented educational materials as tools to stimulate all children. Our children, though exceptional, respond with interest, within their limitations, to play materials that appeal to all children.

Easy access to materials is more important to



This child with muscles weakened by an attack of meningitis uses a pulley to play with a cup of salt, thus getting needed exercise while having the fun of "sand play."

handicapped children than to normal preschool children. Because the child's reach is often restricted by his posture in a wheel chair, spasticity, prosthetic arms, or partial paralysis, we place materials at the edge of tables, along with supplementary tools to help stimulate an extension of his activity.

Because standard tables are inadequate as play surfaces for children in wheel chairs and a work surface that surrounds the child is the most effective design for play, we have designed a table, adjustable in height, with a capacity for six children in wheel chairs to stimulate group interaction. This design will also be used for a sand-and-water table; the depth and indentation of its trays will be shallow enough for easy access to materials.

Play dough has proved to be the most successful medium for manipulative play and tactile experimentation (clay and plasticene are too resistant to pressure for many children).

Over 50 percent of our children are afflicted with congenital or acquired cerebral palsy and have resultant defects in the neuromuscular system which cause deficiency in motor ability and often impairment of eye-hand coordination. Conventional educational materials must be modified if these children are to be stimulated and gratified and are to use play equipment successfully.

To compensate for the incoordination and restricted hand movements of some children, we give them puzzles with knobs on individual pieces, tape all papers to table surfaces, and use only large crayons. Manipulative toys are geared to the motor development level of a 12- or 18-month-old child. Aprons with extensions for covering braces are used for all art work and water and "sand" (salt) play.

Empty baskets are placed near a child working on tasks requiring many pieces of material because it is easier for him to put an object into a container than to place it on a slippery table surface.

Because children with general muscle weakness cannot manipulate conventional unit blocks or construction play items, we provide small, lightweight plastic and balsam transportation toys; small blocks, baby bottles, and coffee scoops for shovels; and miniature models of houses, animals, trees, and people.

Many of our children with cerebral palsy need a one-to-one relationship with the teacher and a very structured program of tasks and play. This is true of the children with the different types of brain damage that lead to difficulties in perception and organization and to hyperactive behavior. Following Cruickshank's experience,¹ we use materials which include well-defined figures in primary colors against a monochromatic background and form puzzle boards with inserts of basic shapes and configurations. We introduce shape discrimination problems in as many different ways as possible. Raised frames are used to outline the form. They add a third dimension to the boundary and offer a border identifiable by touch when visual impression is faulty.

In teaching the language arts, the teacher tries to be aware of the child's distractibility level, short interest span, and poor ability to connect pictures with concrete objects. In selecting books for storytime, we choose those that will expand their restricted world: books that are short and well written, containing simple and realistic illustrations. We try to extend the child's general information with stories about community workers, transportation, domestic animals, food, shelter, and family figures. We take every opportunity to introduce the doctor, nurse, and hospital into stories, puzzles, and discussions. Our dramatic play equipment includes doctors' instruments, real and toy, and rubber figures of hospital people.

Results and problems

After 4 years of operation, serving over 400 children, we realize that our initial reservations about the quantity of "learning" that could take place in a transient nursery school setting were partly justified. Nevertheless, we believe that there has been improvement in most of the children who have attended.

Growth has been greater in some children than in others—but, then, some came to the school less organically damaged than others.

We have seen signs in many of the children of a increased span of interest in play, deeper involvement in materials, broader areas of activity, the beginning of socialization and group awareness, feeling of increased worthiness, mastery of simple skills, more independent action and initiative, aroused curiosity, and the growth of trust in the relationship with teachers, based on the respect and care afforded them in school.

Most of the children, as they become accustomed to the program, display an eagerness to attend sessions, a decrease in withdrawn behavior, a lessening of anxiety, and an increase in spontaneity.

As in most nursery schools, we provide parent whenever possible, with opportunities to share in their child's education through observations and conferences. We try to help them understand the kind of learning experience all children need to grow socially, emotionally, and intellectually and what this means particularly in relation to their child's disability. We also suggest home programs, with individual lists of materials and activities appropriate to the continuation and extension of the child's growth.

One of our difficulties has been in finding suitable nursery school opportunities for our patients after their discharge from the institute. We know that if a handicapped child is not offered *more* than the nonhandicapped child in stimulation, training, and opportunities to learn the lessons of socialization, the effects of his disability are almost certain to increase even though his original disability is not progressive. Nevertheless, unless a child is independent in ambulation, most nursery schools will not accept him even if his intellect is intact. Because we are limited in space, we focused first on the needs of the inpatient. In the new wing we plan to extend services to a selected number of outpatients in an afternoon therapeutic and research-oriented program. We are, however, conscious of the need for expanded additional educational opportunities in the community for preschool handicapped children.

¹ Cruickshank, W., et al.: A teaching method for brain-injured and hyperactive children. Syracuse University Press, New York. 1961.

homemaker services to families with young retarded children

IRENE L. ARNOLD

LAWRENCE GOODMAN

In an effort to bring together two social trends which have been slow to meet—the growing concern for the retarded in our population and the increasing recognition of homemaker services in helping families cope with situations of stress—two voluntary agencies in New York City recently carried out a 3-year project to demonstrate the potential contribution of homemakers and other home helpers toward preserving families of the retarded. Its results may suggest guidelines for the most effective, economical, and efficient utilization of such services in community plans for the retarded.

Established to examine systematically the effectiveness of homemaker and other home-help services to families with retarded children under 5 years old, the project was cooperatively conducted by the Retarded Infants Services, Inc. (RIS), and the Association for Homemaker Service, Inc. (AHS), with support from the Federal Children's Bureau.¹ Behind its establishment was the conviction that such services, perhaps with various levels of integration with case-work services, have an important place in the chain of services required by families of the retarded at the various times in the retarded person's life.

How parents respond initially to the fact of their child's retardation will determine to a great degree the quality of their lifelong reaction to their child, whether or not he remains with the family. The shock of learning that their child will not develop normally may cause them so much inner turmoil—characterized by ambivalent feelings of guilt, sorrow, and disappointment—that they may want to cut themselves off from the offending object by immediately placing the child in an institution or by withdrawing from him emotionally. New and more lasting problems can be created in such a futile effort

to regain a semblance of normality.² If the child is to be placed away from home, the effect of an insufficiently considered decision can result in later self-blame and other manifestations of unresolved inner conflict. Providing the parents with help at the crucial period following their confrontation with the fact of their child's retardation must be the first phase of any broad program for the retarded.

In planning to help families at such a time, the first concern, of course, must be with the accessibility of comprehensive medical and psychological evaluation of the child and of whatever treatment may be indicated. At the same time the provision of skilled casework counseling to the parents can mean for many of them the difference between workable solutions and destructive ones. But also of vital importance are the associated services which may be able to relieve parents of the overwhelming sense of burden sufficiently to permit utilization of other kinds of help. Here is where homemaker services may play a key role. Our purpose was to demonstrate how.

Procedures

The project focused on 35 families. All were drawn from new referrals to RIS. Twenty-four had been referred from general hospital clinics, six from the New York State Department of Mental Hygiene, three from clinics for the retarded, two from private physicians. The intake social worker's determination that the family needed homemaker service was the basis of selecting the family for participation in the project. The only criteria were that the family have a mentally retarded child under 5 years of age and appear able to benefit from the presence of a helper in the home.

Irene L. Arnold, left, is executive director of Retarded Infants Services, Inc. A one-time practicing attorney, she began working in the field of social welfare during World War II with the U.S. Committee for the Care of European Children and later with UNRRA. Lawrence Goodman is social work consultant to Retarded Infants Services and director of social work for the Mental Retardation Center, New York Medical College.



Of these 35 families, 9 were referred to AHS for a conventional homemaker service in which a caseworker and a homemaker, both on the staff of the agency, work closely together as a team; and 20 remained with RIS for service, which included the help of domestic workers called home aides recruited for the family by the agency and some limited casework treatment. A control group of six families received no service but were put on the waiting list for future service.

A clarification of the two terms, "homemaker" and "home aide," seems pertinent. According to the standards suggested by the Child Welfare League of America: "The distinctive elements of homemaker service are (a) placement in the home of a trained homemaker employed as an agency staff member, who works together with a caseworker in carrying out a casework plan to help restore and strengthen parental functioning, or otherwise assure that the child has the care he needs; and (b) use of casework as an integral part of the service. . . ." Homemaker service, as thus described, is closely interwoven with casework.

Home aides, as used by RIS, also are assigned and supervised by caseworkers, but the emphasis is placed on their ability to do light cleaning and cooking and their experience in caring for children, rather than on working consciously with the caseworker to help restore parental functioning. The family may concurrently receive some casework treatment focused on helping the parents reach the best plan for the child's care.

Experienced homemakers from the staff of AHS who were selected for the project participated with the casework staff in a seven-session orientation program. These sessions focused on the condition of mental retardation; the differences and similarities between retarded children and normal children; and

the kinds of parental responses they could expect.

Most of the home aides who took part in the project had had previous experience with RIS. Each was carefully prepared by the caseworker to be aware of the general dynamics of each case situation.

In each case the particular homemakers and home aides assigned to the families were selected on the basis of the caseworker's professional judgment.

The two treatment conditions were not set up for the purpose of measuring the efficacy of one service over the other, but rather to seek further understanding of the impact on families of direct assistance in meeting the burdens of the family's daily routine whether or not this assistance is interwoven with continuing casework treatment. If improvement were possible without the close caseworker-homemaker teamwork, this would seem to suggest that homemaker services for families of the retarded might be offered at different levels of casework involvement depending on the families' need, capacity, and readiness to use total services.

Instruments created for the study included a "family rating form" for measuring the quality of interaction within the family; and a "decision-making form" for evaluating the character and adequacy of the parent's decision about the retarded child at the close of treatment. At the end of the period of service, all participating families were seen by a social worker in a followup interview. In this the interviewer attempted to view objectively the carry-over effect of the treatment received.

Findings

Both the data secured from testing the case material with the measuring instruments and the data from the clinical followup showed improved functioning in the families served by either homemaker or home aides, in contrast to the families which received no service.

The family rating forms indicated that, in contrast to the control group, families served by AHS made important gains in their intrafamily relations as did families served by RIS, though there were some subtle differences between the two groups in the type of changes which occurred. For example, the AHS group showed a greater increase in friendliness among family members than the RIS group, but the RIS group showed greater development in rationality of conduct.

The decision-making forms indicated that families in both serviced groups rated much higher than the

in the nontreatment control group in the quality of plans made for the retarded child. Little difference existed between the AHS and RIS groups.

Similarly, the clinical followup of cases indicated a high degree of sustained gain in families which had received service, regardless of which agency had served them. Some parents who had become involved in relatively intensive casework were able to face openly some of their basic conflicts about their child. However, even families in which the parents regarded the casework they had received as superfluous, but who had a high regard for the help they had received from the homemaker or home aide, improved in intrafamily interaction. Also, the families who had had only occasional encounters with a caseworker focused on specific problems showed sustained improvement.

Thus the findings suggest that, in families confronted with the reality of retardation, help from a homemaker or home aide, selected and supported by a casework agency, can in itself be salutary.

The following two cases illustrate how this may be so at different levels of casework involvement.

The A family

Mr. and Mrs. A were referred to RIS by a diagnostic clinic. At the time of referral, their retarded child Amy was 4 years of age. Her brother James, age 9, had normal intelligence. Mr. A was unemployed because of a strike. Mrs. A said she was at the breaking point because Amy was completely unmanageable, could not be left alone at any time, and had proved to be a tremendous burden to James, who was charged with some of her care.

Both parents seemed immature, demanding, and manipulative. A severe marital problem had developed out of conflict around Amy. The mother was particularly anxious, excusing herself as confused, forgetful, and fearful of harming Amy. Mr. A and his parents were pressing her to send Amy to an institution; Mrs. A was not yet ready to do so.

RIS referred the case to AHS, which sent a homemaker into the home. She was trained not only to assist the mother in carrying the burden of household management and child care, but also to observe changes in behavior and attitudes. Part of her role was to help find out whether or not Amy was educable.

Under the regular supervision of the AHS caseworker, the homemaker assumed a nurturing, maternal role with both the children and the parents, but she was careful not to encourage lingering dependency. Amy responded well to her special attention and soon began to show remarkable improvement. Mrs. A apparently had been too tense to handle her in a way that could bring out her potentials.

James, too, showed improvement. He had not only been relieved of Amy's care, but was also getting more attention from his parents. Soon he seemed less withdrawn and behaved in a more forthright and appropriately aggressive manner.

Mrs. A seemed more relaxed, since for the first time in years she had some time for her own needs. The tension between the parents also relaxed a little, and both seemed to have less need to reject Amy.

The AHS caseworker kept in regular touch with the staff of the referring diagnostic clinic who soon reported that the homemaker services had helped clarify the condition of the child and the dynamics of the family situation. It was then agreed that the AHS caseworker would take over the family counseling role from the clinic and would attempt to bring about better relations between the parents by helping them both to a better understanding of the needs of their retarded child, of their normal child, and of each other. As a result, it became possible to enter Amy into a special day class for the retarded instead of into an institution.

This case exemplifies homemaker service in its complete sense. The steady influence of the homemaker, working in close partnership with the caseworker, expanded the understanding on which a diagnosis could be made, thus making possible more appropriate recommendations for the child's management and care.

As is common with organically damaged children, Amy had responded negatively and with hyperactivity to the anxiety-ridden, erratic handling she had been getting from her parents, and thus her true functioning ability had been obscured. The consistent, well-planned approach of the homemaker helped the child function less destructively and on a higher intellectual level. The resulting decrease of tension in the home increased the parents' ability to make use of casework help. Thus, an institutionalization, likely to be harmful to both the child and the parents, was avoided.

The M family

The following case illustrates the provision of home help chiefly to relieve harried parents while they are mobilizing themselves to adjust to a severe emotional blow.

Mr. and Mrs. M were first known to RIS in 1962 after they learned that their 2-year-old daughter Ruth was severely brain damaged and hopelessly retarded. With the assistance of the agency the child had been placed in an institution. Recently the tragedy was re-enacted. RIS received a call from Mr. M, who was crying hysterically. His wife was in a hospital having an operation and he had just been informed by the family's pediatrician that his 7-month-old son John was also severely retarded. Mr. M seemed to be at the breaking point.

The RIS social caseworker made a home visit the next morning and immediately arranged for a home aide to go into the home to assist Mr. M in the care of both the retarded baby and the family's 5-year-old normal child. Within a few days, Mr. M had recovered sufficiently to go back to work.

After Mrs. M returned from the hospital, the home aide, a person of much warmth and sensitivity, remained in the home to help out while Mrs. M recovered from her physical weakness as well as from the emotional shock of the baby's retardation. At the same time, the social worker and the family pediatrician worked closely together to help both parents accept the diagnosis and again prepare for placing a child in an institution. Mrs. M also received help from the social worker in explaining the baby's condition to the 5-year-old.

Throughout our analysis of the project cases, the effectiveness of the help given by the homemakers appeared most clearly when, as in this case, it was extended to families in the early stages of their response to a crisis. By providing instant help with the burdens of daily existence, the home helper often made it possible for parents to begin to regain enough psychic balance to be able to use casework counseling and help with planning for their child's future.

Some conclusions

The nature of parents' early reaction to their child's retardation—often with the need to deny reality and to isolate all feeling—can block parents from entering into a therapeutic relationship with a social caseworker, as well as from being able to encourage their child's progress or create the kind of emotional atmosphere that can stimulate development. While not all parents respond to a crisis in the same way or experience trauma with the same intensity or duration, many do remain fixed in a state of emotional turmoil for long periods of time. Suppressed anger toward the retarded child, and toward fate in general, becomes internalized and thrust upon the self.

When such psychic turmoil is taking place, the introduction of a homemaker or home aide, who offers warmth and support and provides direct evidence of the community's desire to share their misfortune, can cut through some of the sense of hopelessness. Freed sufficiently to deal with the needs of other family members and to resume activity outside the home, the parents may then be able to perceive the retarded child with sufficient objectivity to consider alternatives in planning and to participate in the kind of continuing casework treatment that can build up the strength in the family. Thus the dynamic potentials of homemaker services go far beyond the practical assistance offered.

We found in the project that most families were enabled to maintain the child at home until a reasoned, reality-based decision about his future had been made. But even when parents proceeded with inadequate planning, the home helper's assumption of many of the responsibilities of the retarded child's care tended to mitigate their guilt and anxiety regarding their child.

Because existing homemaker agencies can obviously play a major role in helping retarded children and their families to a better life, community plan for comprehensive care for the retarded should incorporate such agencies into the overall design and goals of their programming. Ideally, these agencies should be able to provide home help flexibly, according to the varying needs of families of the retarded. Some families can benefit by home help which is not so closely interwoven with casework treatment as is required to help other families. Where such flexibility is not possible, home aide services might appropriately be offered by specialized agencies for the retarded.

While the project described here focused on the needs of families with young children, homemaker service should not be regarded solely as an emergency resource. Actually it is badly needed by many families on a long-range basis. The demands of a severely or moderately retarded child can be so consuming that at least part-time home help may be needed as long as the child remains in the home.

The complex needs of retarded children and the families require bold new planning that includes the creative use and adaptation of existing approaches to families in trouble. Agencies which specialize service to the retarded must provide the direction that will encourage others to open up a variety of previously unobtainable services to families of the retarded.

¹ U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: The value of homemaker service to the family with the mentally retarded child under five. Child Welfare Demonstration Project No. D-66. 1965.

² Begab, Michael: The mentally retarded child: a guide to services and social agencies. U.S. Department of Health, Education, and Welfare Administration, Children's Bureau. CB Publication No. 41. Reprinted 1965.

³ Child Welfare League of America: Standards for homemaker service for children. New York. 1959.

HOW CHILDREN FEEL ABOUT BEING PLACED

SIDNEY Z. MOSS

AWAY FROM HOME

Most children in child-care institutions today have parents. In fact, they have been called "orphans of the living."¹ Thus, when a child is placed in an institution, he faces two difficult adjustments: mastery of the separation trauma; and adaptation to life in the institution. As a former institutional caseworker, I have had the opportunity to observe how some children and their parents can convert an experience of being torn apart into a process which has been described as "moving apart through growth."²

I have also observed how difficult this process becomes when children have not been well prepared in advance for the separation and placement, when they have not been encouraged from the beginning to express their true feelings about these two frightening experiences, and when their parents have not been helped to build and maintain a meaningful relationship with them during the entire period of placement. In this article, I will discuss the effect of repressed feelings on such children after they have been in institutional placement for many months or even years and the implications of this for an institutional casework service.

The children I worked with were in long-term placement in an institution for dependent and neglected children which had only recently begun to offer intensive casework services. Many of them had been separated from their parents through juvenile court action. Many had lived in families in which there was long-time parental discord, alcoholism, or mental illness, and most had been subjected to serious neglect or abuse. Others came from homes broken

by parental desertion, separation, physical or mental disability, or death.

Feelings about separation

The two basic fears of a child are said to be of loss of parental love and of parental desertion. As English and Pearson have pointed out,³ when children lose a parent, whether through death, desertion, or themselves being sent away from home, they go through a mourning experience similar to an adult's after the death of a loved one. But each child must work out his mourning process in his own way. This will be affected not only by the child's own personality, but also by his age, sex, cultural background, the quality of his relationship with the lost parent, and his previous experiences of loss. For example:

Maria, an older adolescent, deserted as a little girl by her parents whom she never saw again, still follows every rumor about their whereabouts, scours telephone books, sees her parents in many strangers' steps.

The loss of a father generally has a more significant meaning to a boy's development than to a girl's. Also, the loss of the mother has a different impact on a girl than on a boy.³ For a boy, a father represents a model of masculinity with which he can identify as he works out his feelings of assertiveness, competitiveness, and independence. Moreover, having a father who can be depended on may help him develop the ability to accept authority in others when

appropriate. Similarly, for a girl loss of her mother represents a loss of an identification model. Also, since children, whether boys or girls, grow with certainty of their mother's love, loss of a mother or loss of her love (which to a child may be the same thing) impairs children's potential to trust in others. The resultant fear of rejection may become internalized as a fear of closeness.

As Charnley⁴ has pointed out, unless children can freely discuss their situation at a time of parental loss, they are led to repress feelings of guilt, shame, ambivalence, and confusion about themselves and their parents and to withdraw into defenses of mistrust, fantasy, and denial. Since placement away from home means parental loss to a child, the child begins with a serious handicap. No matter how well prepared children are for the placement, separation from their parents is still a traumatic experience for them and evokes psychic defenses against the pain. Littner has shown that these defenses, if internalized, can impede the development of other relationships, encourage repetition of the past trauma, and inhibit growth.⁵

No matter how long children have repressed or avoided their feelings about separation, they need to become aware of them to grow not only as independent beings but also in relation to their parents. Children, however, have ambivalent reactions to the idea of discussing their feelings about past separation. On one hand, they thirst for more understanding of the past—particularly of how and why they came into placement. They want to fill in the unknown facts and feelings of their past to know more about themselves and what they want to become. On the other hand, they do not feel strong enough to bear the pain of exploring their feelings. Glickman⁶ has observed that a child resists discussion of his feelings about separation because he is afraid to "lose all chance to return to the family, a hope he clings to in fantasy or unconsciously."

Often children who resist discussing their parents in the hope that they will change are those whose parents are most inconsistent and rejecting. These are the parents who talk about taking the child home but never make any plans, who promise to visit the child and do not, who rarely write to him, who forget his birthday, and who care little about the child and his needs. Such children suffer deeply since they are constantly confused about what to expect from their parents. But they cannot express their resentment because of their hope that the parents might magically change after all, or because of their

fear that the parents might sever the tenuous connection they have. Such children may transfer their conflicting feelings about their parents to the institution itself. Although they wish to trust their parents to meet their emotional needs, they are not sure they can, and this ambivalence is repeatedly acted out in erratic behavior in the institution.

A child may also hide his feelings about separation behind a pseudo-mature objectivity. Outwardly, he is like an adult; inwardly, he is the child torn with yearning for his unmet dependency needs to be met.

Joan, a pre-adolescent in placement many years, believe intellectually that her mother, who recently married, has: right to live a life of her own; but at the same time she is terribly hurt, depressed, and confused by her mother's rejection and preference for a strange man over her.

Children also resist discussing their parents when they have no home to go to. This is often true when their parents are dead.

Children are very protective of their parents, ready to defend them against any criticism, direct or implied. Many feel so much a part of their parent that to reveal any negative feelings about them seem like an indictment of themselves. They often war to be like their parents regardless of the way their parents have treated them.

Sybil, recalling her mother, who was sexually promiscuous and alcoholic up to her death, literally worships her mother as if any criticism of her meant complete rejection.

Children search for every scrap of attention they ever received as proof of their parents' love. They cannot bear to let their parents be considered neglectful or their love so weak as to have permitted separation to occur. Children cling to their old ties, no matter how destructive the parent-child relationship in the absence of certainty about the new relationships available to them.

Children's resistance to discussing their feelings about their parents is also strengthened by the fact that a mere mention of parents reminds them of the reality of their placement and of their sense of abandonment, which they must deny to avoid pain. Some children accordingly meet mention of the parents with an air of indifference.

Johnny, an adolescent, has been in placement many years. He cannot remember his previous life in his parents' home. His mother died when he was 4 and he only vaguely remembers her funeral. His father is still living but rarely visits him in the institution. Johnny has built a wall around himself

He has no interest in his father now or in connection with the future. A sullen, withdrawn boy, he bullies other children and tortures animals.

* * *

Jimmy, a 10-year-old child, was deserted by his father shortly after he was born. His mother placed him with a relative, whom he thought was his mother until she died. Then his mother immediately had him placed in an institution. Now Jimmy cannot remember his substitute mother. He has little feeling for his own mother except resentment that she placed him so quickly. He knows that his father is alive but prefers to consider him "dead." "What's the difference, he does not see me." Jimmy has made sexual advances to a child of preschool age. He now shows suicidal tendencies.

Some children resist discussing their parents because they do not want to give them up as objects upon which to project their resentment of the world. They need to reject their parents until the parents make up for their pain. Such children develop a superficial, exploitative, and demanding attitude which is carried into all relationships.

Mae, an older adolescent, was placed for institutional care by deserted "father" who suspects she is not his, although he does not tell her this. Desperately wanting him to love her but unable to trust in his feelings toward her, which she senses as ambivalent, she denies any feeling of affection toward him. Laying on his sense of guilt, she demands money and expensive gifts whenever she sees him. He complies but with deepening resentment.

Some children resist discussing their feelings about their parents because no one has ever before been concerned about how they feel and they do not see why anyone should be concerned now. Others feel relieved in finding that the caseworker understands a little of what it means to be a child in placement but resent the fact that nobody discussed their feelings with them when they first came to the institution. Some express a feeling of futility, saying that discussions about their parents now can have little value except as painful reminders of the past and of the pointlessness of the future.

Feelings about placement

As Rose has pointed out,⁷ many children having been neglected before the placement have had little opportunity to develop a capacity for creative adaptation under stress. Although the institution may offer such children the kind of security and consistent good care that are conducive to healthy growth, they need to discover the positives in the situation them-

selves before they can deal effectively with their pain. There is pain in their efforts to reconcile the fact of their placement with their parents' expression of concern for them; pain in finding their worst fears confirmed—that their parents did not love them enough to keep them—especially bitter if they have brothers and sisters who have been kept home; pain in not knowing if they will ever be back with their parents, who are often vague in regard to their intentions; and pain in feeling inadequate and helpless in an unpredictable world—a feeling expressed in the frequent question, "What will happen next?"

Most institutionalized children seem to have little idea of how and why they came into placement or what is planned for their future. Many do not remember at all how they came, who brought them, and how they felt at the time. This may be due to their swift acceptance for care, without appropriate preparation, explanation, or help in dealing with their pain. Their primary means of defense then was to repress all feeling.

Sometimes parents have been unaware of their own motivations and so unable to give the children adequate reasons for the placement. Some parents who in their childhood have themselves been placed away from home unconsciously earmark a child for placement out of a need to repeat their past in working out their own unresolved conflicts.

Joan, according to her mother, was born at the wrong time—when the mother was depleted physically and emotionally. When Joan's father died, her mother let the grandmother take care of her for a while and then placed her in the institution. The mother later remarried. Joan, now 12 years old, longs in vain to return to her mother, who continues to reject her. The mother has created the same situation with her child that she, herself, experienced as a little girl. She, too, lost her father, was quickly placed, and longed desperately for years to return to her mother, who remarried but had no room for her.

Sometimes a deserted mother has taken her revenge on the child.

Jane, whose father left home shortly after her birth, was placed in the institution at an early age because she was a constant reminder to her mother of the father's desertion. At the time of placement the mother said she could not handle the child until her husband returned. Actually, she had never wanted the baby, whose birth she felt was the cause of her husband's desertion. Jane, now 7, yearns for her lost father, but does not want to be returned to her mother.

Unable to accept the fact that their parents wanted to get them out of the home, some children blame the placement worker. They accuse the worker of talking the parents into it or stealing them when their

parents were out. A child may feel that his placement came about by accident, that if his mother had not needed to go to a hospital on a particular day the placement worker would not have come to get him.

A child may initially see the institution as providing protection. But as years pass without adequate planning for the child's future, the child tends to see the institution as a permanent provider and becomes increasingly dependent upon it. If he cannot plan for the unknown future or master the trauma of his separation, he drifts complacently in the present.

When the caseworker discusses the possibility of reunion, the children frequently express a desire to stay in placement. They are afraid to leave the security and dependability of the institution. This is especially true of children who have been in placement for a long time. They want to avoid the risk of a more independent life and the need to work out a relationship with their parents; but they rationalize their resistance to reunion and may say they want to remain where they are for several years longer so they can graduate from school with their friends or that they do not like the neighborhood where their parents live.

Some children deny that there is anything to prevent them from returning to their parents. They seem unaware of their parents' rejection or inability to care for them at home and fantasy that when they want to go home all they need to do is to ask their parents to take them. Other children blandly shrug off any discussion of going home to avoid the possibility of further anxiety and rejection. In fact, some children, emotionally drained by a long placement, may no longer be able to show much feeling for their parents.

Some children are realistic when the subject of reunion with their parents comes up. They have little faith in their parents' capacity and stress the value of security and dependability in the institution. They

realize that their father cannot hold down a job or that their mother is unable to provide clean clothes, regular meals, and an adequate home for them.

Underlying some of the children's strong feeling of dependency on the institution may be the failure of the institution to encourage the parents to be actively involved with the child while he is in placement. The child's awareness that his parents see undervalued may reinforce his own sense of inadequacy and lead to increasing reliance on the institution as a substitute family, at the expense of a developing sense of autonomy.

Identity problems

Children who have had little opportunity to express their feelings about separation and have had little sense of their own participation in the decision for placement tend to be anomic, with a diffuse sense of identity and little capacity for relationship. Having little idea of the reason for their placement, they have little sense of direction and consequently feel helpless. They have no plans for the future or when the caseworker brings up the subject they may ask, "Where were you when I needed you? It's too late now."

Even if the caseworker and the child develop specific plan for the future, the child is likely to react with confusion, indecisiveness, and failure to follow through. When it is made clear to him that he is expected to follow through with whatever plan has been chosen, he may regard the expectation as rejection and react with anger or stubborn refusal.

The present may have little meaning for an institutionalized child. Said one, with a shrug: "What's a birthday? One day is just like another—like death."

Time spent in placement with no distinct goals can be death-like. Only a succession of discrete moments without continuity and direction, it fails to provide the momentum for growth, and the child is unable to proceed toward self-fulfillment. Lawder has pointed out how a child long in placement may retain the same symptoms of distress that he showed at the beginning.⁸ He cannot move beyond that point unless he has been helped to understand the reason for all the goals of the placement.

A child who has only a vague sense of identity feels an aching loss and a desperate need for other people to make up for what he does not have, or to support what he does have. Yet, filled with both rage and self-hate, he is not sure he can trust in any human

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relationships. His energy is dissipated in clinging to others in an insatiable dependency bond, which gradually eats away his capacity to be a person in his own right.

Such a loss of identity prevents a child from seeing himself as the key person in charge of his own fate. Struggling with loneliness, he develops few interests, sees things only in black and white, "reacts to" rather than "feels with" other people, and tends to regard people as objects to fill immediate needs. Having little sense of autonomy, he thinks mainly in terms of what others want him to be; and having little sense of purpose he marks time and avoids full use of the institutional program or staff relationships. Since growth is possible only when time is, to employ an expression of Thomas Mann, "sanctified by its creative use," such a child needs help in developing a sense of control over his time or destiny so that he can use the placement experience creatively.

Some implications

Thus, in working with institutionalized children, it is essential to deal with their feelings about separation from their parents as early as possible before they are blocked by repression. Ideally, casework treatment with this focus should begin well before placement, or, if this is impossible, immediately afterward and should be carried on as long as the child is in placement, for pain and psychic conflict inflicted by parental loss are deep and tenacious. However, even when a child has been in placement a long time without having a chance to discuss his feelings freely, sensitive caseworker may help him do so.

While the institution's caseworker may also help the child accept his parent's decision to place him away from home, the placement agency should impress upon the parent the importance of giving the child the initial explanation so that he may gain strength from the feeling that behind the decision was concern for himself. Similarly, the agency should make it clear to the parents that they are expected to keep in close touch with their child during the whole time he is in placement so that he can feel strong in his identification with his family, the source of so much of his individuality.

The agency's goals in accepting each child for

placement also should be made clear to his parents, or parent, at the beginning of placement so that they will understand the importance of their full and continuous involvement in support of the agency's plan for the child. A clear understanding of what is expected of them can help motivate parents to maintain a positive connection with their children through responsible visiting, letter writing, backing plans to meet his medical needs, and working with the staff in his behalf. When parents are so involved, the children can learn to see the parents as they are and to value their strength and respect their limitations. This helps them make better use of the placement experience.

An institution must develop understanding of what it can expect from parents. Some parents may not be able to support a placement plan; some may be able to relate to their children in placement but may be against reunion; others may be realistically hopeful of having their children at home once more; still others may need help to relinquish their child so that he can be free for adoption or a foster-home placement.

If it becomes evident that a child may need to stay in long-term institutional care, this should be made clear to both parent and child, but the plan should be reviewed periodically.

Whether parent and child can be reunited or need to stay apart, the growth of each separately and in relation to each other is the placement goal.

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THE

DEVELOPING

INFANT

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Infant psychiatry was almost a brand new field when René Spitz published his earliest reports of hospitalism and anaclitic depression among infants living in institutions.¹ His data made clear that psychopathological developments occurring in the first year of life could be traced to intense or extensive emotional stress and deprivation, and that they set limits upon subsequent maturation or even upon life beyond infancy.

Then came his important monograph on the smiling response, coauthored by Katherine M. Wolf.² His subsequent publications have been composed mainly of clinical and theoretical additions to these data.

Spitz already has had the satisfaction of seeing many followers elaborate or refine his explanations of infant behavior. One therefore might hope that his latest book, "The First Year of Life,"³ would offer an organized summary of his more than two decades of work on the subject, and would present his view of questions still needing clarification. Unfortunately, the hope is not fulfilled.

The first part of the book describes psychological achievements of infancy which Spitz believes mark milestones in the normal development of object relations—that is, the quality of mental representations of people and things outside the subject's own body. The

second deals with psychopathological conditions found among institutionalized infants. The third, an addendum by a collaborator, Geoffrey Cobliner, compares some classic psychoanalytic concepts about infantile mental life with the theories of Piaget.

In the first two parts of the book, Spitz recapitulates the major theses he advanced between 1945 and 1964, but he provides no adequate account of which observations yielded which data. Yet the findings serve as bases for broad and unwarranted generalizations about cultures as well as about infants.

Still, this book presents major contributions to the psychology of infants. The theories concerned with pathology have had the most direct influence upon other investigators. Since most infants are outside institutions or foster homes, however, it seems well to deal here with Spitz' considerations about normal development, especially with two of his basic theories: the perceptual capacity of the young infant, and the "organizers" of development in the first 15 months of life.

Infants' perceptions

Spitz describes two types of perception in infants. The first is an undifferentiated perception of a mass of body sensations ("coenesthetic perception"). It is "extensive, primarily visceral, centered in the autonomic nervous system," and is "manifested in the form of emotions." The second, the distinguishing perception of outer stimuli ("diacritic perception"), is achieved through the peripheral sense organs as the infant develops.

Spitz regards the mouth as the central organ allowing for a transition from the primary undifferentiated reception of sensations to the differentiating perception of external stimuli. However, it is questionable whether the mouth is the earliest perceptual organ. Data fast accumulating suggest that the eyes and ears play a concomitant early perceptual role. Spitz says that a "shift from contact perception distance perception" occurs through the infant's staring at the mother's face while he sucks the nipple. This implies that infant feeding experiences are far more uniform than they are. In defense of his thesis, Spitz says "Neither [direct observation nor experiments] will yield much information from the neonate, for his behavior is random, unstructured, and his responses are inconsistent"; and he directly supports this statement by reference to the work of Fantz and von Senden.

Fantz has produced increasing evidence that neonates have innate preferences for perception.³⁻⁵ Spitz argues that, though Fantz' subjects did visually distinguish differences, this does not mean that they perceived patterns. Meeting, he says, is not form perception. By just assuming, however, that infants do not perceive but merely select one cannot nullify the significance of Fantz' findings, which indicate the existence of cortical functioning from birth.

Even more strange is Spitz' discussion of von Senden's studies of persons who were born blind and necessarily developed nonvisual modes of perception and who in later childhood

*Spitz, René A.: *The First Year of Life*. International Universities Press, New York, 1965. 394 pp. \$8.50.

or adulthood gained vision through surgery.⁸ Von Senden's subjects found it almost impossible to make use of their new visual capacity. Spitz maintains from this evidence that visual perception is not innate. A biological comparison of the visual learning of the once-blind to the visual responsiveness of the newborn hardly seems justified.

The organizers

Spitz has taken his second theme, the concept of "organizers" from embryology, in order to describe three achievements during infancy as being of peak importance for the infant's development of object relations. The three achievements are: the responsive smile which appears at 3 months; an "anxiety" in the presence of strangers, at 8 months; and a head-shaking "no" gesture, at about 15 months. When currents of development are integrated with functions and capacities resulting from maturation, Spitz says the outcome is a restructuring of the psychic system on a higher level of complexity: "This integration . . . when successful, leads to what I call an 'organizer' of the psyche."

In embryology, an organizer is a substance that serves as a tissue transformer, the transformations being fixed by the constitution of the tissues. It is neither an integrative process nor an indication of a process, but something which induces a process of structural differentiation, and which may lead to the formation of additional organizers.⁹

Spitz' use of this concept to build a "genetic field theory of ego formation" does not succeed despite its clinical appeal. For example, the responsive smile at 3 months seems to be a maturational attainment rather than something that induces a structural differentiation. Spitz seems to overlook his own findings regarding the developmental deviations of infants deprived of appropriate stimulation, findings which show that stimulating experiences are almost prerequisite to the appearance of the smile. Nor does he make any reference to the numerous studies, following his own with Wolf,¹⁰ of the vicissitudes of the smiling response before and after the third month of life among infants in various kinds of environments.

Spitz' second "organizer," the "8-month anxiety," has had even less con-

fimation. Several observers have indicated that the symptoms of anxiety in the presence of strangers that may appear at about 8 months are not universal. "Anxiety" may be, in fact, a misnomer for what does appear.

Like Benjamin⁸ we have observed that most normal infants around this age do not show an emotion resembling fear, but often show a cautious visual inspection of strangers or a temporary freezing of social response, without any turning away at all.⁹ Frank anxiety at sight of strangers at about 8 months may be developmentally inappropriate, an excessive reaction.

The "no" response

The third "organizer," the head-shaking "no" gesture, is said by Spitz to mark the infant's first achievement of an abstract concept, at approximately 15 months of age. He believes that the precursors of this achievement are the neonatal reflex rooting pattern—a search for food—and at 6 months the head movement from side to side which has the converse function of food avoidance. While some elements of this theory may be valid, as presented it contains numerous factual errors. For example:

1. ". . . every 'No' of the mother represents an emotional frustration for the child." The fact is that often it takes a long time for the toddler to recognize the "no" as anything but a stimulus for gleeful repetition of the disapproved act.

2. "The six-month-old baby, when he is satiated . . . turns his head from side to side, avoiding the nipple, or the spoon, in one word, the food—with the very same rotatory movement which at birth served him to seek food." Among 120 infants of this age observed (in film) during entire feedings,¹¹ only 5 showed this head-shaking behavior: 4 between willing acceptance of spoonfuls of food, and 1 on waking from sleep.

3. "The mastery of the 'No' (gesture and word) . . . presupposes that he has acquired the first capacity of judgment and negation." Actually, babies may make many judgments before this—they decide which objects belong in mother's purse or in the refrigerator; which are edible or tearable, and which

are not. They note essential relationships though they cannot yet isolate either by gesture or word the quality that establishes the relationship between objects. Perhaps the 15-month-old infant's "no" means mere refusal rather than negation.

4. "With the acquisition of the gesture of negation, action is replaced by messages, and distance communication is inaugurated." What of the earlier visual and auditory messages that mother and infant send to each other, using facial expressions, or sounds that entreat, complain, command, or reassure?

5. ". . . the first abstract concept [expressed in the semantic symbol of "no"] is acquired with the help of a displacement of aggressive cathexis [here meaning negative emotions toward objects]." Apparently, Spitz uses the term *abstract concept* to mean the idea that something can *not* be, rather than as a classification made on the basis of similarities between objects. True, a *selection* of the object-to-be-refused is accomplished by aggressive energy and a resulting *classification* is expressed in a symbol. But the "no" of refusal or resistance indicates only that objects are to be fended off, and not that they have any class relationship.

Object relations

Throughout his work Spitz has drawn attention to infantile maladaptations that may simultaneously influence both emotion and intellect and has shown that an adequate theory of normal infant development must encompass the progression in the infant's development of affect and of object relations. But Spitz moves too quickly when he postulates a "field theory" of object relations by connecting three isolated infantile responses in the first 15 months of life, that have not all been proved to be of great importance. These responses may reflect or have a bearing on the state of an infant's relations to the outer world, but many others may be found to be equally, or more, significant.

Actually, only the first of the three responses, the smile, is an approach response; the other two are avoidance responses. This suggests that these particular responses made such a strong impression upon Spitz because almost all of the infants he studied were not

living at home and were lagging or deviant in social development.

Spitz' brilliant work on the responsive smile at 3 months perhaps made it natural for him to regard this achievement as the first peak in the development of the infant's relations to the outer world. The subsequent disappearance of the smile in the second half of the first year, exaggerated to an "anxiety reaction" among infants who were either emotionally neglected or erratically stimulated may have seemed conspicuous enough to be a second peak. But between the ages of 8 and 15 months, a normal infant makes other enormous developmental advances. Most obviously relates to his growing awareness of others as separate from himself are his ability to walk away from and back to his mother; to make playful imitations of sounds and gestures; and to play hiding games.

A paradox

No one has reacted with displeasure to Spitz' reports of the normal appearance of the responsive smile in the third month of life. In contrast, many have been appalled to learn of the severe psychological damage suffered by infants in institutions. The infants Spitz has reported on were foundlings, or were living in a penal institution with their mothers. The starkness of their deprivations have made questions regarding the constitutional determinants of their maldevelopments seem irrelevant or impertinent. Yet when milder disturbances are observed among infants or young children living at home, the question of constitutional etiology is usually raised.

Surely a continuum from "worst" to "best" exists in conditions in institutional settings as well as in family homes. In view of this fact, one wonders why Spitz so often idealizes the usual mother-infant relationship. For example: "From the moment the mother comes into the room to the end of nursing [the infant] stares at his mother's face."

Numerous observers have been perplexed by this repeated statement since it is at odds with their own observations. Running films of over 110 infants fed by their mothers through the first year of life⁹ have shown that most babies, breast fed, bottle fed, or even cup fed, rarely look at the mother's face (or are helped to do so) before, during, or after feedings.

A place in history

Wherever Spitz has relied upon direct observation and clinical understanding for his conclusions or new hypotheses, his work has achieved great distinction. The "psychotic disturbances" (rocking, colic, eczema, fecal play), for example, which came to his notice through his work on anaclitic depression, will provide other investigators with ample hypotheses for further studies. It is therefore regrettable that wherever he has not taken time to differentiate between assumptions, hypotheses, and general conclusions, he loses his stimulative effect.

Nevertheless, Spitz is assured of a lasting place in the history of infant psychology. In a period when his contemporaries were concerned almost exclusively with reconstructions about infancy, he dared to look at real live babies, facing the danger that his observations might disprove basic psychoanalytic theories. He brought to attention the importance of the infant's emotional life and dependence upon the mother, without postulating either an adultomorphic structure, a simple reflexive one, or one in which the infant became the source of his own difficulties. He made the psychological life of the infant plausible.

In interpreting his findings, Spitz showed that infancy was far more complex than had thus far been implied; that the first year of life is long enough and complicated enough to afford oceans of investigation; and that within its span, cumulative experiences are more likely than single traumatic events to

lead to lasting pathological reactions in the child.

The subjective nature of many parts of Spitz' presentations reflect his eagerness to arouse in others a comparable dedication to the emotional lives of infants, and may be accounted negligible as long as we keep in mind the central issues: that the stimulation and deprivation of the infant can have specific and cumulative effects upon his social attachments; and that the nature of these attachments may facilitate or preclude the realization of his biological potentials.

Except for the Pavlovians in the field, practically all investigators since Spitz in some way have had their work shaped by his. This is more of an achievement for a man than to have all of his statements proved true.

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. . . the most forgotten, neglected individual in our society today is the fetus. . . .

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HERE and THERE



Family planning

More than 1,000 persons met in Washington, D.C., for 2 days in May at the national Conference on Family Planning, sponsored by Planned Parenthood-World Population and Planned Parenthood of Metropolitan Washington. They represented 65 national organizations in the fields of health, welfare, education, religion, civil rights, labor, and industry—including Protestant, Catholic, and Jewish groups. Meeting in general sessions and in smaller panel sessions, they considered family planning services as a right which should be accessible to all and as a necessity to control the world's exploding population.

In the general sessions, two United States Senators—Joseph D. Tydings of Maryland and Ernest Gruening of Alaska—urged stepped-up Federal action to deal with what President Johnson has termed "humanity's greatest challenge . . . second only to the search for peace"; representatives of the Department of Health, Education, and Welfare—Under Secretary Wilbur J. Cohen and Chief of the Children's Bureau Katherine B. Oettinger—told of Federal activities to promote research in fertility control, the expansion of family planning services as a part of maternal and child health, and the training of professional persons to provide the services; Secretary of Agriculture Orville L. Freeman spoke of the untereffects of population pressure and efforts to raise the level of nutrition in the developing countries; and Alonzo Yerby, M.D., New York City Commissioner of Hospitals, described the development of a network of family planning services for low-income families through the city's public hospitals.

Other city family planning programs—provided through health departments, hospitals, or anti-poverty community action programs—were outlined in some of the 11 panel sessions. As described, the programs were alike in stressing availability to the poor and insistence on the patient's right to choose which method of family planning, if any, she will employ; but they differed in whether or not they made efforts to "reach out" to persons considered to be in need of the services or to follow up on those served, and the availability or unavailability of their services to unmarried women.

There seemed to be a consensus that family limitation is no longer a controversial issue so long as freedom to choose is respected; but that there may be a moral question in whether or not unwanted children should be brought into the world. Some uneasiness was expressed, however, as to the effect of the availability of "the pill" on the sexual behavior of young people.

Pointing out that "a child has a moral and legal claim to be legitimate," a Catholic priest said he could not see how the social harms would be increased by permitting contraceptive counseling to a person who has already made a decision to enter upon an illicit relationship, that in his eyes the relationship and not the contraception was the evil. Another participant posed the question of how to engage in an effective education program about contraception for those young persons who are already engaged in sexual relations, "without stimulating or disturbing those who ought not to be reached."

There were warnings against the dangers of coercion in a family planning program focused chiefly on the poor. A priest pointed out, "We forget

that the poor can also communicate human values and ideals." And a demographer, maintaining that the recent population explosion in this country was largely due to "over-wanting" on the part of couples who do control their family size, suggested an educational program to change the image of the ideal middle class family to one of only two or three children.

The chief accent in the conference was, however, on the poor and the effects of the combination of poverty and high fertility on family disorganization. George N. Lindsay, chairman of Planned Parenthood-World Population, reported a research-based estimate that 5 million fertile impoverished American women who want medical instruction in family planning are not receiving it.

The conference produced no formal recommendations, but reports from the panel groups accented the following needs: greater financial support for services, training, and research, especially from the Federal Government; more opportunities in medical schools for clinical practice in fertility control; more attention to rural areas, widespread educational programs about the availability of family planning; the inclusion of the concept of family planning in family life education programs in the schools; and increased aid to foreign countries in establishing family planning services.

On August 8, the 87-year-old legal ban against the dissemination of information about contraceptives and birth control will be lifted in Massachusetts, the last of 11 States to have had such a law in effect. Under a new law, passed in May, physicians will be permitted to prescribe contraceptives to married persons and public health and welfare agencies to furnish information on where contraceptives can be lawfully obtained. The new law, however, does not apply to unmarried persons.

Public assistance

New requirements to protect the dignity and rights to privacy of persons receiving or applying for public assistance, by respecting their constitutional and statutory rights, were issued by the Bureau of Family Services, Welfare Administration, in March 1966,

and will become effective July 1, 1967. Under these requirements, in order to receive Federal financial participation in their public assistance programs, States must show in their 1967 public assistance plans that prompt action will be taken on assistance applications, that "applicants and recipients will be relied upon as the primary source of information about their eligibility," and that "verification of conditions of eligibility will be limited to what is reasonably necessary to assure that expenditures under the program will be legal."

The interpretation accompanying the new requirements pointed out the need for States to "guard against violations in such areas as entering a home by force, or without permission, or under false pretenses, making home visits outside of working hours, and particularly making such visits during sleeping hours; and searching in the home, for example, in rooms, closets, drawers, or papers, to seek clues to possible deception."

The requirements were issued under the provisions in the Social Security Act requiring State public assistance plans to provide methods of administration necessary for "proper and efficient operation" and to include "reasonable standards" for determining eligibility "consistent with the objectives" of the program.

Mid-Decade Conference

The nearly 550 participants at the Mid-Decade Conference on Children and Youth, held in Washington, D.C., on April 12-15, looked back and ahead in considering the welfare of the Nation's young. They looked back to the 1960 White House Conference on Children and Youth to see whether the recommendations made then had been carried out, and they looked forward toward a possible 1970 White House Conference to see what should be done between now and then to fulfill the promise of the 1960 Conference. The Conference was sponsored by the National Committee for Children and Youth, the National Council of State Committees for Children and Youth (representing 42 State and territorial committees), the Council of National Organizations for Children and Youth (representing 360 national voluntary agencies), and the Interdepartmental Committee on Children and Youth (rep-

resenting 38 Federal agencies). The participants included many young people.

At the opening general session, Ruth Stout of the Kansas State Teachers Association maintained that the young are "still criticizing us for what they criticized us in 1960." Wilbur J. Cohen, Under Secretary of Health, Education, and Welfare, pointed out that public and voluntary agencies have a great opportunity to achieve "three parallel goals": maximum coverage of all programs serving children and young people; broad community support for and understanding of current programs as rapidly as possible; and the improvement and extension of programs in response to change.

Much of the work of the Conference was done in small discussion groups at which participants reported on local programs and discussed the direction they thought future action should take. Participants also divided for one session into small seminars on health, family life, education, the disadvantaged, delinquency, and other topics relating to the welfare of the young.

Some participants reported that communication between groups and agencies working for the young was poor. Others, however, cited examples of close work between groups at all levels. Many maintained that programs were concentrating on economically deprived children to the exclusion of "deprived" children from affluent homes. They recommended setting up projects of interest to all young people. Many suggested that young people be brought into projects not just as representatives of youth but as active participants.

At the closing general session, Catherine V. Richards of the Children's Bureau, in summarizing the findings of the discussion groups, identified the following areas as needing action:

- *Family life*—Because it is an indispensable condition to meeting the child's right to basic subsistence, every family should have an income equal to its needs. Public welfare allotments should be increased to meet current cost of living. Efforts should be made to improve the life of parents as individuals. Ways must be found to let them know what services are available to them without making them feel incompetent if they use them. Children should have sex education and preparation for marriage and family life.

There should be more services for unwed parents and for children born out of wedlock.

- *Health*—The gaps should be closed between the need for and the provision of prenatal care, well-baby clinics, and preventive medical care for children and young people. Efforts to control narcotics, alcohol, tobacco, and automobile accidents must be intensified. The public must be made aware of the need for better nutrition for all children.

- *Social services*—Better resources are needed for identifying potential dropouts at an early age. We must provide more day care, nursery school, group homes for adolescents, and well-planned correctional programs. Programs for emotionally disturbed children should include integrated services for the prevention and treatment of their condition close to home.

- *Education*—Education should include preparation for work, experience in solving problems, and help in learning to live with others. Every child should have an opportunity for as much education as he can master; training in a skill should be open to those who do not go to college. Provision should be made for continuing education.

- *Research*—Research should be conducted on such subjects as the effect of urbanization on the family and the child and on the causes of such problems as births out of wedlock, student riots, violence, and juvenile delinquency.

- *Equal opportunities*—Every effort should be made to bring about equal opportunity for education, employment and housing.

Mental retardation

Current knowledge and theories about the biochemical mechanisms involved inborn errors of metabolism and the treatment of children having such defects were discussed at a 3-day conference on phenylketonuria and allied metabolic diseases, held in Arlington Va., in April, under the auspices of the Children's Bureau and the University of Minnesota Department of Pediatrics. Participants were 65 scientific authorities in the fields of metabolism, medical care, and public health.

Major attention was focused on phenylketonuria (PKU), a disease characterized by high levels of phenylalanine in the blood which often results, when untreated, in mental

ardation. Speakers and discussants suggested a number of areas in which research is needed to track down the still elusive mechanisms in this disorder which cause mental retardation—or, for example, studies of the pharmacological effects of the metabolites, such as phenylethylamine.

Some controversy emerged in discussions of the widespread use of a low phenylalanine diet in treating the disease. Several participants reported clinical evidence of increased intellectual acumen in children given the diet for PKU; others questioned the assumption of the diet's beneficial effects in evidence not derived from controlled studies. The possibility of the development of protein deficiency, with adverse results, if phenylalanine levels in the blood became too low was also raised.

Other differences of opinion emerged in discussions of State laws requiring the testing of all children for PKU and their metabolic disorders. While some participants advocated such laws for their casefinding value, others maintained that they would hamper efforts to find improved treatment methods.

The full proceedings of the conference will be published by the Children's Bureau soon.

Mental health

A 2-year study of the mental health of children is being undertaken by the joint Commission on Mental Health of children, recently organized by the cooperative action of 13 professional and scientific organizations in response to the 1965 amendment to the Social Security Act which authorizes Federal expenditure for studies of emotional illness in children (Public Law 88-97). In May, the National Institute of Mental Health awarded the commission \$500,000, effective June 1, 1966, for the first year of its study, the maximum amount could be awarded under the law. The study will be carried on by task forces drawn from participating professional organizations and through contract with university research centers and similar institutions.

The purpose of the commission is to study all aspects of the problems of mental health in children and to formulate comprehensive plans and programs for dealing with these problems. A nonprofit, voluntary organization, it is organized by the American Psychi-

atric Association, the American Academy of Child Psychiatry, the American Academy of General Practice, the American Academy of Pediatrics, the American Association on Mental Deficiency, the American Association of Psychiatric Clinics for Children, the American Medical Association, the American Orthopsychiatric Association, the American Psychological Association, the National Association for Mental Health, the National Association for Retarded Children, the National Association of Social Workers, and the National Education Association.

The commission's board of directors includes 40 members, some representing the organizing societies and others chosen by the executive committee as persons with special competence.

In addition, there are eight liaison representatives from Federal agencies. Joseph M. Bobbitt is the commission's executive director. Its headquarters are in Chevy Chase, Md.

Child abuse

Many of the families of children reported as abused to the New York City Department of Welfare have deeply rooted social or personal problems, according to a study recently completed by the Columbia University School of Public Health and Administrative Medicine, under a grant from the Children's Bureau.

Begun in May 1965, the study was conducted by two public health physicians, Betty Simons and Elinor F. Downs. Its purpose was to inquire into the effectiveness of the State's new law (passed in 1964) requiring the reporting by physicians, and other health personnel, of suspected or confirmed child abuse and to obtain information about the epidemiologic and demographic facts of child abuse in New York City. It was conducted through interviews with staff members of social agencies and the review of information extracted from the Central Registry of Child Abuse, set up by the New York City welfare department's bureau of child welfare in 1964 to record cases reported under the law. This material was supplemented by case records made available by the department of welfare and the several voluntary agencies providing protective services in the city.

The investigators found that during the first year the law was in effect, 313

cases of suspected child abuse in 293 families had been reported. Two-thirds of the children were under 5 years of age; one-third had histories of past abuse. Patterns of abuse ranged widely and did not lend themselves to "flat definitions and categorizations," according to the investigators. The families represented a wide variety of cultural backgrounds and the child abuse among them a complex of symptoms including in many instances mental illness.

As a result of 1966 legislative sessions, Mississippi, Virginia, and the Virgin Islands now have laws requiring physicians to report suspected cases of child abuse; and Maryland amended its law which, among other changes, provides for a central registry on child abuse.

In Mississippi and Virginia reports of suspected abuse are to be made to youth courts and juvenile courts, respectively. Maryland's new law requires reports to be made to local welfare departments.

Hawaii is now the only State without a child abuse reporting law. Other jurisdictions without such laws are Puerto Rico and the District of Columbia. In the District of Columbia, pending legislation, passed with differences by the U.S. Senate and by the House, is awaiting action of a conference committee.

Manpower needs

Nearly 100,000 additional social workers with graduate degrees will be needed by 1970 by public and voluntary welfare, health, and educational agencies to carry out programs in which the Department of Health, Education, and Welfare has a direct concern, according to the findings of a 3-year study conducted by a special Departmental task force.

This figure was based on estimated needs for additional professionally trained social workers in the following programs: public assistance programs, 31,500 more; public child welfare services, 10,000 more; schools, 17,000 more; juvenile delinquency treatment programs, 11,500 more; community mental health programs and mental hospitals, 10,500 more; hospitals, clinics, and other health facilities, 12,000 more; and services for the aging, 3,200 more.

In addition, the task force reported, most of these programs will need more

college graduates who have had undergraduate courses in social work and more high school graduates with vocational training qualifying them for ancillary tasks.

Pointing out that even these estimates do not take into account the effects of the 1965 amendments to the Social Security Act, the task force has recommended:

- The expansion of graduate and undergraduate training facilities and of programs of financial aid to students, including scholarships.

- The development of a special undergraduate curriculum to prepare the students for direct entry into social agencies after receiving a bachelor's degree—to be followed by on-the-job training.

- The establishment of regional recruiting committees, with paid staffs, to encourage young people to enter the field of social work.

- The adoption of better salary scales and the provision of career opportunities.

- The establishment of a center for the continuous receipt and analysis of data on social work manpower needs.

The report of the study, "Closing the Gaps in Social Work Manpower," is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, for 55 cents a copy.

Child welfare research

Thirty-six specialists in child care attended a 3-day workshop on group residential care of infants and young children, held in New Haven, Conn., March 31–April 2, 1966, under the sponsorship of the Children's Bureau and the Yale Child Study Center. The workshop was called as part of a Children's Bureau effort to encourage a re-examination through objective research of some of the issues concerning the group care of infants and young children. Participants represented the disciplines of social work, child development, psychology, education, psychiatry, pediatrics, and public administration.

Among the participants was Anna Freud, director of the Hampstead Clinic, London, who described some of her experiences with the group care of children evacuated from London during World War II. She expressed approval of the efforts in this country to re-ex-

amine the issues of group care, but recommended that more attention be given to the values and use of foster family care and special day-care programs. She also raised questions about the "current preoccupation" here with the cognitive development of children, to the disregard of their needs as a whole.

Other participants presented papers on the developmental needs of the infant and preschool child, existing programs of group care of young children, problems of staffing for group care, planning the daily experience of the child, planning the physical environment, the residential facility and the community, and health needs of young children in group care. In the ensuing discussions, participants blamed much of the limitations in current child welfare services on the lack of insufficient funds and staff, but they also maintained that the adequacy of services was limited by a failure to develop modes of foster care based on current knowledge and theory in the fields of child development, psychology, and learning.

The proceedings of the workshop, which was under the chairmanship of Sally Provence, M.D., of the Yale Child Study Center, are to be published by the Children's Bureau.

A new research project on cost analysis in children's institutions was initiated last February under the auspices of the American University School of Government, Washington, D.C., with a 3-year grant from the Children's Bureau. The project, which is under the direction of Robert Elkin, has four objectives: (1) to produce a simplified cost procedure for children's institutions for widespread annual administration using local resources; (2) to analyze the time and cost data produced in about 60 institutions using a manual on cost analysis developed by the Child Welfare League of America; (3) to experiment with developing a classification system for institutions which will identify different levels and sizes of program operation; and (4) to study the feasibility of developing a model for or system of cost-benefit analysis in children's institutions.

The new project will build on the results of study completed last spring, also directed by Mr. Elkin, by the Child Welfare League of America and the Children's Bureau, with a grant from

the Field Foundation. One of the principal findings of the earlier study is that the system of cost analysis must be simple enough to attain widespread annual usage and at the same time useful as a base for building a more complex system for institutions which need to analyze complicated cost issues. The study also found that the issues of technical consultation and training must be considered thoroughly; and that personnel trained to administer cost analysis system are crucial to success.

Sheldon and Eleanor Glueck of the Harvard Law School are cooperating in a project in Puerto Rico which employs some of the procedures used in their research on characteristics of juvenile delinquents, first reported in their book "Unraveling Juvenile Delinquency" (Harvard University Press for the Commonwealth Fund, Cambridge Mass., 1950). Some of the same tests and inventories that were used in the earlier study are being administered in the Puerto Rico project to 300 delinquent and 300 nondelinquent youth matched on the basis of age and cultural background. Included also a several additional measures, such as skull X-ray and electroencephalogram records, and several newer project tests.

The purpose of the project is to identify causal factors in juvenile delinquency.

The project is being financed by the University of Puerto Rico, the Government of Puerto Rico, and the U.S. Office of Education.

Health care

By June 1, health agencies in nine cities and one rural area had received grants to set up comprehensive health services for children and young people living in neighborhoods with many low income families. In addition to the Chicago Board of Health (see CHILDREN, May–June 1966, p. 123), the awards have been made to—

- Beth Israel Hospital, Boston \$224,000, for a project to serve children and young people in Roxbury, Mass., the hospital, a clinic in Roxbury, and in their homes.

- Minneapolis Health Department Bureau of Maternal and Child Health

1,049,440, to work through the Henne-
in County General Hospital, child
clinics in the city, work service centers
or high school students, the University
of Minnesota hospitals, and other
agencies.

- Ohio State Department of Health,
olumbus, Ohio, \$1,089,671, to set up
"5 C's" program (Comprehensive
are Clinic of Columbus Children's
hospital), at the Columbus Children's
hospital. The project will serve chil-
ren and young people in Columbus,
Franklin County, and several other
ounties in southeastern Ohio.

- Children's Mercy Hospital, an
ffiliate of the University of Missouri
chool of Medicine, Kansas City, Mo.,
939,514, to cover a low-income city
ra including about 51,000 families.

- New York City Department of
ealth, \$413,535, to operate the Rocka-
ay Health Center of the Queens Hos-
pital Center for children and young
eople living in the Rockaway Penin-
ula (an area geographically isolated
om the rest of the city).

- New York University Medical Cen-
er, \$1,589,738, to cover the area served
y Bellevue Hospital. The project will
clude a Medical Records-Information
etrieval Center for all children served
y Bellevue to record medical and
cial information for the use of Belle-
ue and other institutions.

- Johns Hopkins Medical Institu-
ons, Baltimore, Md., \$1,252,555, to
erve children and young people in a
½-mile radius of the Johns Hopkins
ospital.

- Baltimore City Health Depart-
ent, Baltimore, Md., \$2,066,125, to
erve children and young people in the
inner city through two teaching hos-
pitals—the University of Maryland
ad the Sinai Hospital. The Presby-
rian and the Baltimore City Hospi-
als are to be included as the project
velops.

- Children's Hospital of Philadel-
ia, \$443,950, to cover an area of
outh Philadelphia adjacent to the
ospital.

- State Services for Crippled Chil-
ren. University of Iowa, Iowa City,
owa, \$340,308, to serve children and
ung people in the rural areas of
arke, Lucas, Decatur, and Wayne
ounties through multi-purpose centers
each county.

All projects will cooperate with other
ublic and private health agencies in

the community; public and parochial
school systems; university medical
schools and hospitals; and local, State,
and Federal welfare agencies including
Project Head Start. The projects will
also include informational programs
for parents to encourage them to use
the centers.

With the initiation of a program in
Ohio this spring, all 50 States, the Dis-
trict of Columbia, and Puerto Rico are
now conducting health referral and
ounseling programs for young men re-
jected by the Armed Forces for medical
reasons. Under the program, which is
sponsored by the Public Health Service
in collaboration with the Vocational
Rehabilitation Service, designated
State agencies have received contracts
from PIHS for services—offered at
Armed Forces examination stations—
to advise rejectees on their health prob-
lems and to refer them to health and
rehabilitation facilities in their own
communities. Follow-through by the
rejectee is entirely voluntary.

The program has served more than
151,000 young men since it began in
1962, with pilot projects in New York
City and Philadelphia, on the recom-
mendation of a subcommittee on com-
munity services for Selective Service
registrants of the Interdepartmental
Committee on Children and Youth.
(See CHILDREN, January-February
1962, p. 35.)

Unmarried parenthood

Attitudes toward unmarried paren-
hood differ, sometimes greatly, among
unwed mothers, their parents, and pro-
fessionals who serve them, according
to the findings of a project recently
completed by the Research Center
of the Columbia University School
of Social Work. The project, directed
by Deborah Shapiro, was initiated by
the Salvation Army, Eastern Territory,
and supported by a grant from the Chil-
dren's Bureau. It involved the ques-
tioning of 134 unwed mothers, 65 of
their parents, and 100 staff members of
two Salvation Army hospitals in New
York City and Cincinnati, Ohio. Re-
spondents were asked to rate their at-
titudes on a scale, going from strong
acceptance on the one hand to strong
rejection on the other, toward state-
ments regarding the morality, respon-

sibility, and underlying values related
to unmarried motherhood.

Only 29 percent of the unmarried
mothers among the respondents were
20 years old or older. About 35 per-
cent were still in high school. Sixty-
seven percent were white; all others
were Negro. Among the white mothers,
61 percent were classified as from upper
lower class families, 25 percent from
middle class families, and 14 percent
from "unstable" lower class families.
Among unwed Negro mothers, all but
four were classified as from "lower
class families." Of the staff members,
88 percent were classified as middle
class professional men and women or
middle class white-collar workers; the
others were classified as lower class
semiskilled or unskilled workers.

The project found that the respond-
ent's role—unwed mother, parent, or
staff member—seems to have more
bearing on his attitude than differences
in race and social class. The greatest
difference in attitude was noted between
the unwed mothers and hospital staff
members, although the difference be-
tween unwed mothers and their parents
was almost as great. Middle class un-
wed white mothers differed from both
parents and staff members. Lower class
unwed Negro mothers differed most
from staff members, less from their pa-
rents. Lower class unwed white moth-
ers agreed with both parents and staff
members almost as often as they
disagreed.

The majority of respondents in all
groups said they believed all sexual be-
havior should be confined to marriage.

The project concluded that the wide-
spread assumption that Negroes accept
illegitimacy more readily than whites
is only "relatively true," that although
lower class unwed Negro mothers are
more likely to respond in a way which
suggests mixed feelings than lower class
unwed white mothers, both groups have
ambiguous sexual mores.

The project also found indications
that staff members of the participating
agencies gave their clients appropriate
immediate service, but were likely to be
hampered by the social distance be-
tween client and staff in reaching long-
term and more complex goals.

In all three samples Negro respon-
dents more frequently than white re-
spondents said they would prefer keep-
ing a child born out of wedlock rather
than placing him for adoption.

BOOK NOTES

THE MATURATIONAL PROCESSES AND THE FACILITATING ENVIRONMENT: studies in the theory of emotional development. D. W. Winnicott. International Universities Press, New York. 1965. 295 pp. \$6.75.

This book is a collection of papers on psychoanalysis and child development prepared between 1957 and 1963 when the author was a physician at Paddington Green Children's Hospital in England. Stating his theme as "the carrying back of the application of Freud's theories to infancy," the author stresses the role of dependence in healthy or pathological personality growth.

The papers focus on some of the processes in achieving specific goals of child development—including the capacity to be alone, the capacity for concern, independence, and moral values—and on the contributions of various theories to the techniques of treating antisocial, mentally ill, or neurotic children and adolescents.

TEACHING THE CULTURALLY DISADVANTAGED PUPIL. Compiled and edited by John M. Beck and Richard W. Saxe. Introduction by Robert J. Havighurst. Charles C Thomas, Springfield, Ill. 1965. 335 pp. \$10.50.

The 16 essays in this book, by college instructors, educational researchers, and elementary school administrators, discuss the problems of the culturally disadvantaged pupil and what can be done through education to help him break out of the cycle of poverty. They are grouped under three general headings: basic characteristics of the disadvantaged pupil; the disadvantaged pupil in the elementary school; and the school and community and the disadvantaged pupil.

In the introduction, Dr. Havighurst maintains that we have enough research on disadvantaged children to show that emphasis should be placed on preschool

and elementary school experiences.

The essays in the first section draw upon research in anthropology, sociology, and psychology in analyzing the problems of the culturally disadvantaged pupil and the instructional programs that can help him. In one, the author, William E. Gorman, points out that a distinction must be made between the culturally different child—who may not be disadvantaged—and the culturally disadvantaged.

The essays in the second section, by subject-matter specialists, describe teaching procedures which have proved successful in working with disadvantaged pupils in various subjects.

Essays in the third section discuss the preparation of teachers and the major responsibilities of school administrators and communities for the education of disadvantaged pupils.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume XX. Ruth S. Eisler, Anna Freud, Heinz Hartmann, and Marianne Kris, editors. International Universities Press, New York. 1965. 566 pp. \$10.

This 20th volume in an annual series contains 25 contributions grouped under 4 major sections: diagnostic assessments (chiefly concerned with discussions of Anna Freud's "diagnostic profile"), aspects of normal and pathological development, contributions to psychoanalytic theory, and clinical contributions.

Three reports are included on research with blind children. Doris M. Wills reports that the blind nursery school children she observed seemed to have their own way of thinking. She suggests that the blind child may have to be helped to think in his own way before being taught how to adapt to the world of the seeing.

Dorothy Burlingham describes the problems of motor restraint, verbalization, and object recognition in blind children. She disagrees with the widespread belief that blind children have

unusual acoustic and tactile ability. "... what blind children really possess to an extraordinary degree," she says "is an excellent memory made more and more efficient by constant inward looking."

Humberto Nagera and Alice E. Colonna cite evidence suggesting that ego development in children blind from birth is retarded by lack of necessary visual contributions as well as by attitudes toward the blind.

Among other articles are papers on early male adolescence, inhibition of aggression in infancy, and impaired ego development in children with physical malformations.

WILDERNESS ROAD. Campbell Longmiller. Hogg Foundation for Mental Health, University of Texas, Austin. 1965. 139 pp. \$2.50.

This book describes the program of 24-hour, year-round camp for treacherously disturbed boys.

In contrast to most residential treatment centers which provide treatment, daily program, food and lodging for the patient, Camp Woodland Springs, sponsored by a Dallas service club, requires the boy and his parents or parent engage themselves in a treatment planning conference with the institution's caseworker, administrator, counselors, and others, according to the author. He tells how the boy and his unit group of nine develop their own daily and weekly program in collaboration with two adult counselors; and how they build their own rustic shelter, cut wood for fuel, cook half their meals, and review their day's accomplishments in regular evening group discussion.

Education and rehabilitation through daily accomplishment, self-involvement, and relationship with supportive adults and buddies form the core of the treatment program described. The staff makes creative use of daily experience at home and in trips through near States in helping the boys deal with their emotional problems.

HEALTH AND THE COMMUNITY readings in the philosophy of sciences of public health. Edited by Alfred H. Katz and Jean Spence-Felton. The Free Press, New York. 1965. 877 pp. \$12.50.

The 76 papers in this book on aspects of health and the community have been selected from a variety of professional

journals and other publications as representing a broad view of practice and research that, according to the editors, limits of "the possibility of obsolescence and change" while retaining basic attitudes, values, and goals."

They are classified under eight general subjects: changing social conditions and health needs; the people served; arenas of health service; the sciences and disciplines of public health; changing emphasis in public health; innovations and adaptations; special studies; and goals and priorities in a changing world. Included are papers on deaths associated with childbirth; prenatal factors in the production of neuropsychiatric disorders; mental retardation; job opportunities and youth; teenagers and venereal disease; school health programs; malnutrition and child health; and public health dental programs.

MODES OF THINKING IN YOUNG CHILDREN: a study of the creativity-intelligence distinction. Michael A. Wallach and Nathan Kogan. Holt, Rinehart and Winston, New York. 1965. 357 pp. \$8.

This is a report of a rigorous investi-

gation of "the ability called creativity." The authors are psychologists: Dr. Wallach, at Duke University; Dr. Kogan, at the Educational Testing Service. They set out (1) to determine whether they could find sound evidence to support their assumption that creativity and intelligence are distinct modes of thinking and (2) to find the possible psychological correlates of individual differences in creativity and intelligence when variations in both are considered at the same time. As a result of their investigation, they conclude that creativity and intelligence are separate and that permissive conditions are necessary if creativity is to flourish.

The investigation involved 70 boys and 81 girls, 10 and 11 years old, in the fifth grade of a public school in a New England town. All were from middle-class families. The study took nearly 7 weeks, including 2 weeks of observation only. Tests of various kinds were given under play conditions, always without a time limit.

The children fell into four groups: intelligent and creative, intelligent and not creative, creative but not intelligent, and neither creative nor intelli-

gent. The intelligent but not creative children seem to be making out the best in school. The creative but not intelligent children seem to be having the most difficulty and were often disruptive in the classroom. Differences also existed between boys and girls in the same groups.

The book includes chapters on behavior, categorizing and conceptualizing, sensitivity to physiognomic properties, the role of anxiety and defensiveness, and studies of individual children. In the concluding chapters, the authors discuss the implications of their findings for education.

SOCIAL WORK PRACTICE, 1965: selected papers, 92d annual forum of the National Conference on Social Welfare, Atlantic City, New Jersey, May 23-28, 1965. Columbia University Press, New York, for the National Conference on Social Welfare. 1965. 253 pp. \$6.

The 17 papers in this book were selected from the papers on casework, group work, community organization, and social action presented at the 92d annual forum of the National Conference on Social Welfare.

in the journals

Parent education

In the April 1966 issue of *Nursing Outlook*, Edith L. Amend describes the parent education program at Children's Hospital of Philadelphia, of which she is the coordinator. ("A Parent Education Program in a Children's Hospital.")

Four parts of the hospital's program, she maintains, have insured good hospital-parent relationships: (1) conferences with parents before a child's surgery; (2) instruction for parents of cyclomenogeocele patients, infants who must remain in the hospital, and diabetic children; (3) unlimited visiting hours; and (4) a teaching program for lay nursing staff.

"Because the ultimate care of the child rests with parents," she points

out, "great efforts must be made to strengthen family relationships during hospitalization." At the same time, she says, it is important "to coordinate the hospital's efforts to insure parents that their child will receive good care, and that there will be continuity of this care when they take him home."

Smoking and birth weight

A study of more than 2,500 mothers in Baltimore, Md., who smoked or did not smoke during pregnancy, described in the April 1966 issue of the *American Journal of Public Health*, by James R. Abernathy, Bernard G. Greenberg, Bradley Wells, and Todd M. Frazier, confirmed the results of an earlier study of these mothers by Mr. Frazier and others. ("Smoking As an Independent

Variable in a Multiple Regression Analysis Upon Birth Weight and Gestation.") Both studies found that babies born to mothers who smoked tend to be smaller than babies born to non-smoking mothers though there is little difference in the gestation periods.

The authors maintain that the agreement between the findings of their two studies is "singularly important" because their present analysis was conducted with "due consideration of the multiple characteristics of the mother"—such as her smoking history and whether she had hypertension or eclampsia.

The authors suggest that one possible common characteristic in the smoking mothers may have been a reduced flow of blood across the placenta during pregnancy. Such a reduction, they maintain, if it existed, could have adversely affected the intrauterine growth of the fetus. When a satisfactory method of measuring the flow of blood

across the placenta is found, it will be possible to study the effect of smoking on the flow of blood, the authors conclude.

Genetic counseling

Two articles in the April 1966 issue of *Social Work* discuss genetic counseling in social work. ("The Challenging Opportunity for Social Workers in Genetics," by Sylvia Schild of Children's Hospital, Los Angeles, and "The Impact of Genetic Disorders," by Amelia L. Schultz, of the Clinical Research Center, University of Washington, Seattle, Wash.)

In the first, the author maintains that genetics counseling offers great opportunity for the application of casework services. Family planning and genetic counseling are not, she points out, synonymous. In genetic counseling, the social worker's job is to identify some of the psychosocial problems that genetic disorders can bring to a family and to help the family solve its problems, especially to help each member overcome the injury to the ego that discovery of a genetic disorder can bring to a person.

In the second, the author discusses many of the factors involved in the reaction of a family to the discovery that

the parents carry genetic disorder. Although "it may be some time before many social workers are employed generally in genetic clinics," she maintains families facing the problems genetic disorders bring do come to the attention of social agencies. The social worker can help them face the threat to life or social functioning, accept the rejection of other people, and work out a way of meeting the financial strain that may be imposed. "If social workers are aware of these possibilities," she concludes, "they may increase their sensitivity to genetic problems and their helpfulness to those who suffer from them."

readers' exchange

MALUCCIO: *More about support*

Agencies are familiar with the stress-producing effects that emotionally disturbed children have on foster parents, so well described in Anthony Maluccio's article. ["Selecting Foster Parents for Disturbed Children," by Anthony N. Maluccio, *CHILDREN*, March-April 1966.]

Therefore, we must try to understand why this happens and what can be done to remedy the situation. Such understanding would have implications for methods by which we select foster parents, the process of matching children with foster parents, and the casework services provided for foster parents.

As Elizabeth A. Lawder has already pointed out elsewhere ["Toward a More Scientific Understanding of Foster Family Care," *Child Welfare*, February 1964], to effect a careful matching of a child with a foster-parent couple, we have to know more about the interests, motivations, and aspirations of the prospective foster parents than can be gleaned from the standard home study.

In the home study devised in the Merrifield Center, a project sponsored by the Worcester Children's Friend Society and the Worcester Youth Guidance Center with a grant from the National Institute of Mental Health, besides the usual criteria for selecting foster par-

ents, the following criteria are considered essential in selecting foster parents for emotionally disturbed children: (1) sufficient comprehension of the temporary nature of placement to enable them to help the child maintain ties with his own family if advisable; (2) the ability to cooperate with the agency in closely shared responsibility; and (3) the ability to respond to a learning experience.

Recognizing the need such foster parents have for support, Merrifield Center (1) periodically conducts group-training program meetings for the foster parents; and (2) schedules weekly casework conferences with individual foster parents beginning when they are asked to consider a specific child and continuing as long as he is in their home.

Peter E. Reinhold
Project Executive, Merrifield
Center, Worcester, Mass.

PAULSEN: *What is neglect?*

Monrad G. Paulsen has performed a valuable service in reviewing the general legal framework in which the problem of child protection is now being handled. ["Legal Protections Against Child Abuse," *CHILDREN*, March-April 1966.]

Mr. Paulsen makes an important point in stressing that protection of the

children is the vital consideration rather than punishment of the parent. Unfortunately, there is considerable variation of opinion on what constitutes such protection.

Mr. Paulsen comments: "What judge is likely to characterize 'neglect' will, I believe, depend upon action which he feels called upon to take." This would seem to leave decision open in specific cases to particular bias of the judge, and practice this does happen. The definition of neglect is particularly vulnerable to subjective influence.

Mr. Paulsen seems wary of tackling the question of when permanent removal of a child from his natural home is necessary, and of the relation to the degree of abuse. Yet these questions must be faced if we are to protect children in fact as well as in theory.

While there can be no argument with Mr. Paulsen's advocacy of a "multidisciplinary network of protection in each community," it should be pointed out that the effectiveness of such network will depend on the willingness of its participants to study realities of the problem and to act according to those realities.

The law assumes that parents are effect the advocates for their child. When this is so, there is no problem. When this is demonstrably not true, question is: Who are the child advocates?

Leontine R. Yo
Executive Director, Child Services
Association, Newark, N.J.

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MENTAL RETARDATION ACTIVITIES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Annual Report, January 1966. Department of Health, Education, and Welfare, Office of the Under Secretary, the Secretary's Committee on Mental Retardation. 1966. 87 pp. 50 cents.

Part I of this publication summarizes the various aspects of the Department's concern with mental retardation and the recent Federal legislation under which its mental retardation programs are operated. Part II describes the specific mental retardation programs of the HEW agencies. Appendices present information on Federal authorizations and expenditures for fiscal years 1965 and 1966 by type of activity and administrative agency.

FACTS FOR COMPREHENSIVE HEALTH SERVICES FOR CHILDREN AND YOUTH—POLICIES AND PROCEDURES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 27 pp. Single copies free on request from the Bureau.

An outline of the procedural requirements and staffing standards estab-

lished by the Children's Bureau for the special projects to provide comprehensive health care for preschool and school-age children in low-income areas authorized under a 1965 amendment to title V of the Social Security Act.

SERVICES FOR CHILDREN: how title V of the Social Security Act benefits children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 17 pp. Single copies free on request from the Bureau.

Answers 24 questions about the nature and purpose of the grant programs administered by the Children's Bureau.

THE PRACTICE OF NURSE-MIDWIFERY IN THE UNITED STATES. Margaret W. Thomas. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 436. 1965. 61 pp. 25 cents.

Reports on a study of the extent and nature of nurse-midwifery practice in the United States in 1963-64. (See CHILDREN, May-June 1965, pp. 122-123.) Also includes a substudy de-

scribing the attitudes of physicians toward nurse-midwifery.

YOU CAN QUIT SMOKING. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 433. 1965. 19 pp. 15 cents.

Addressed to teenagers who want to stop smoking, this pamphlet offers suggestions to help young people hold to their decision to stay away from cigarettes. The guidelines offered are based on the experiences of many teenagers who, after making the decision to stop smoking, succeeded in giving up cigarettes.

BREAST FEEDING YOUR BABY. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 8. 1965. 27 pp. 10 cents.

This booklet offers suggestions for the mother's diet while breast feeding her baby, for care of her breasts, and for weaning. It also points out that breast feeding can be an enjoyable and comfortable, emotionally supportive experience for both mother and infant.

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children

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THE PROFESSIONS SERVING CHILDREN

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children

Adolescent Unwed Mothers

Training Child-Care Workers

Dental Care for Children

Young Human Service Aides



children

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On her first visit to the dentist this little girl is obviously interested in the efforts of the dentist and his assistant to become her friends and to make her as comfortable as possible. The importance of dental attention in early childhood for preventing serious oral disease in later life is discussed in the article beginning on page 177.

children

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The unwed pregnant adolescent girl presents both a dilemma and a challenge to the helping professions. In part, the dilemma stems from the lack of understanding of the mixture of medical, emotional, and social problems involved when the phenomena of adolescence and out-of-wedlock pregnancy occur concurrently.

Until recently, those services that do exist for unmarried pregnant girls have tended to focus their attention on girls from middle or higher socioeconomic groups, while girls in the lower socioeconomic brackets have received little service. But even those girls who do receive services, planning tends to be fragmented to meet a particular need and has included little of the coordination of services essential to insure a comprehensive approach to the problem. However, in recent years there has been increasing recognition among both professional and lay groups that services to the disadvantaged teenage unwed mother are especially important, and that these services must be community-oriented and designed to meet her physical, educational, and mental health needs.

Pregnant girls and their families in the lower socioeconomic brackets have many characteristics in common with girls from middle and upper class backgrounds who are faced with the problem of out-of-wedlock pregnancy, and I believe we indulge in pure fantasy when we assume otherwise. However, they also carry additional burdens and special problems often unknown to and not experienced by persons of other classes. Many of them are from families in which communication with one or both parents is largely nonverbal; in which men are rarely seen as part of the sustaining continuity of family life; in which the "good father"—if there is one—is seen primarily as an economic provider in which the mother feels she has little control over her own fate and even less over the fate of her children in which serious and chronic medical problems are common. In addition to these disadvantages, these girls are stereotyped by the community as persons who feel no shame for having babies out of wedlock and who are poorly motivated, untreatable, and unperturbed by unacceptable social standards.

Isolated from community resources, such girls are rarely known to any social agency except a public assistance service. Many of them do not make sustained use of what medical resources are available to them until they arrive at a hospital at the point of delivery—confused, frightened, and unprepared. Few resume schooling after their babies are born.

COMPREHENSIVE SERVICES for

adolescent unwed mothers

MATTIE K. WRIGHT

In Chicago, in 1963, we made a modest beginning toward meeting the needs of such girls. It was only beginning, for we were faced with an extensive problem: the rise in the number of cases. In 1964, for example, Chicago Board of Health reports indicated that 2,833 girls of 17 and under had given birth out of wedlock. In 1965, this number rose to 3,144—an increase of 11 percent. Over 75 percent of these girls resided in areas of the city characterized by the lowest per capita incomes, the highest rates of illegitimacy, and the lowest levels of educational attainment; 83 percent in 1964 and 85 percent in 1965 were Negroes. (These figures, of course, do not give the full picture because of under-reporting and "hidden pregnancies" in middle class groups.)

Concern over the lack of coordinated services for these girls prompted the Mental Health Division of the Chicago Board of Health, in February 1963, to set up the Community Services Project. This demonstration was designed to meet on a small scale the comprehensive needs of a selected number of unwed pregnant adolescent girls. Initially supported by a 3-year grant of \$169,000 from the National Institute of Mental Health, the project received a 4th year of support to try to build the program into the fabric of basic community services. This is now being done, as I will describe further on. The project, carried out through the collaboration of the Board of Health, the Board of Education, the Juvenile Court, the Community Referral Service, and a number of voluntary hospitals, offered an array of medical, educational, and mental health services without charge to pregnant girls who were living at home in unfavorable environments. At first, it served only 15 girls at a time, all of them under 16. In 1964, it

served 30. All were Negro girls from areas characterized by poor housing, crowded schools, minimal job opportunities, and family disorganization. Many of them were from families in which the only adult was a mother or a grandmother.

An office was secured for the project in a public housing unit, situated in a culturally and economically deprived area of the city, inhabited predominantly by Negroes. In the beginning the staff consisted of a full-time director (a social worker), an additional social worker, a psychologist, a consultant psychiatrist, a teacher, a project coordinator (also a social worker), an administrative assistant, and a secretary. A second staff social worker was added in 1964. In addition, in November 1964, nurses studying for a master's degree in psychiatric nursing at the St. Xavier's College of Nursing were assigned to the project for their field work. Previously, nurses from the Chicago Board of Health instructed the girls in prenatal and postnatal care.

The following criteria were established for admission to the project: The girl must have been in elementary school; in her first pregnancy; not beyond the 7th month; without serious medical problems; and interested in attending school. Girls who were formerly students in classes for the mentally retarded were generally excluded from the project, although some exceptions were made.

Educational program

While the initial planners of the project were convinced that medical and mental health services for these girls should be given major attention, they decided that offering the girls an opportunity to

participate in an accredited school program was basic to insuring their involvement in the total project.

The educational phase of the program, offering both academic and home arts curriculums, was carried out in a large classroom in a YWCA center located in a housing project which also contained a mental health clinic, a Board of Health prenatal station, a district office of the Cook County Department of Public Aid, and a district office of the Youth Commission. The proximity of these facilities was of great advantage in coordinating services and maintaining a close working relationship between the staffs of the different agencies.

The Board of Education provided the teaching staff, work materials, carfare, and lunch. The school routine and curriculum approximated, as much as possible, those of a regular school classroom.

Early in the project it became apparent that one teacher could not be expected to have proficiency in both academic and home arts subjects, nor could she be expected to provide the remedial and individualized instruction that most of the girls needed. Therefore, in June 1964, the Board of Education replaced the one teacher in the project with two experienced elementary schoolteachers—one trained in academic subjects, and the other in home arts. It was then that the enrollment was expanded to 30 girls.

The teachers placed special emphasis on increasing the girls' incentive and self-direction. They also encouraged the girls to assume responsibility for completing work assignments, caring for materials and

equipment, and showing consideration for their fellow students, teachers, and visitors.

A hot lunch, brought in from a nearby high school, was served daily. This not only insured that the girls got at least one well-balanced meal a day, but it also provided opportunity for instruction in table setting, serving methods, table manners, and clean-up. Each girl was encouraged to learn to work efficiently and quietly while performing the house-making tasks, to be polite, to converse in a pleasant voice, and to eat a variety of foods.

The skill, sensitivity, and warmth of the teachers enabled them not only to create an atmosphere of learning in which the girls felt secure and accepted but also to stimulate the girls to raise their level of achievement. Many of the girls responded with greater self-discipline and purpose, not only in their academic performance but also in their behavior and attitudes. They showed marked regularity in school attendance, in contrast to their generally erratic attendance when they were in regular school.

The prescribed curriculum was enriched by weekly arts and crafts class in knitting, crocheting, embroidery, rug-hooking, and toy-making, conducted by a volunteer. For three summers, a college student, recruited by the Careers in Social Work program, offered individual tutoring in reading to girls especially needing it. In addition, the YWCA offered the girls classes in typing and personal improvement after the regular school day ended.

From February 1963 through February 1966,

Five teenage unmarried mothers participate in a group discussion with the social worker (left center) and the director (center) of the Community Services Project, Chicago. In such meetings, staff members acquire better understanding of the needs and the girls acquire better understanding of their problems and of ways of solving them through using their own ability.



1390 girls referred to the service. Of this number, 108 girls were accepted into the program. The remaining 282 girls were not accepted for the following reasons: advanced stage of pregnancy; chronic physical illness; severe emotional problems; mental retardation; inability to involve the girl's family; limits of project capacity. The excluded girls, however, were accepted for medical care by the cooperating health services.

Of the 108 girls who participated in the project, 60 percent were referred by the Board of Education or the Board of Health's infant welfare stations. Their ages ranged from 11 to 16 years, with median age of 14. Fifty-nine percent were living in one-parent homes (mother or grandmother only). Almost one-third of the participating girls had themselves been conceived out of wedlock. The median number of months the girls had been pregnant when admitted to the project was 5; the lowest number, 2; the highest, 8. Eighth grade was the median school level, but a few girls were in the sixth and seventh grades. Seven months was the median duration of enrollment in the project's school—1 month, the shortest period, 14 months, the longest. The ages of the babies' fathers or putative fathers ranged from 14 to 34 years, with a median age of 17 years. Many were unemployed school dropouts.

Medical services

Comprehensive medical care, including prenatal, delivery, and postnatal care, was provided for the girls by the Board of Health's Maternity and Infant Care Project, with support from the Children's Bureau.¹ Facilities used were the Board's maternity clinics, its infant welfare stations and special pediatric clinics for high-risk babies, and 12 participating voluntary hospitals. Costs which could not be borne by the girls or their families were borne by the Maternity and Infant Care Project, or, for girls who were receiving public assistance, by the Cook County Department of Public Aid.

In addition, the student in psychiatric nursing arranged special hospital visits for girls close to delivery, visited each girl in her home before delivery and immediately upon her return home, and conducted weekly maternal health discussions with the girls at the school. These meetings were divided into two sections—one for pregnant girls and the other for girls who had already had their babies. They were geared to providing essential health information and at the same time to helping the girls

handle constructively the feelings and attitudes associated with their condition.

Excerpts from a report of the health discussion groups by one of these nurses, Judith Meehan, reveal something of the needs of these girls:

... Although I found gross lacks in the girls' knowledge of the basic facts of life, I did not find this surprising or out of the ordinary for this age group. However, without the opportunity for weekly group discussions, I would not have known or been able to ascertain in what areas the deficit was the greatest, and, therefore, needed specific and special attention to fill.

However, what the girls did not lack were gross misconceptions and misperceptions about their bodies—about the function of their bodies and about the care of their bodies. There was a definite need, therefore, to unlearn these misconceptions, misperceptions, and superstitions upon which they have been operating; and then, there was a definite need for factual information from me for the girls to use as a substitute—a realistic substitute. Some common questions and ideas expressed by the girls were: "How come the baby does not drown if it's in a bag of water?" "How do people have babies out of their side?" "Why do some people have stitches and some don't?" "What are the baby's soft spots for?" "If I lift my hands above my head, will the baby strangle?" . . .

It was with their profound curiosity about life—anything and everything—that I often found myself working. Eventually, I became conscious of my stimulating, nurturing, and fostering their curiosity as a very profitable and satisfying means of learning—as a gratifying substitute for their present learning via physical experience only. . . .

... Fear of pain during delivery was the most often expressed feeling. Guilt about being pregnant also came up often, but in a sense, it often felt to me like guilt about anything and everything—as if an apology for being alive.

Possibly the greatest demand on me and by me was to convey to each girl that she was important to me—that her ideas, questions, feelings, and thoughts about whatever she wished were important to me. . . .

Mental health

The third focus of the project—the promotion of mental health—involved individual and group counseling, psychological testing, and psychiatric consultation. In addition to scheduling periodic individual interviews with each participating girl, the social workers offered regular interviews to their mothers. However, shortly after the project went into effect, the social workers found that both the girls and their mothers felt threatened by individual interviews and broke many appointments.

Constant reaching out over a sustained period was often required to get both the girls and their mothers involved. Because of the common life experiences of the girls and their mothers, problems in communi-

cating, and social isolation, the staff decided to complement the individual casework interviews with group discussions. We found that the group approach not only furthered our diagnostic understanding of the conflicts, strength, and needs of the girls and their mothers, but also improved both the girls' and their mothers' ability to work on their problems.

The girls met in groups of 12 to 15 each, once a week, for an "educational process and problem-solving discussion" led by the caseworker but carried on chiefly through a free and spontaneous exchange. The emphasis was on problems of living, self-directed learning, stimulation of varied interests, and expansion of horizons. Because these girls tended to be "action-oriented," to respond to the here-and-now, to be "doers" rather than "reflectors," and to fail to see relationship between cause and effect, attempts were made to build on what they had—to help them learn from their experiences and the experiences of others and translate, abstract, and generalize from these experiences rather than to view them in isolation or as something that "just happened to me."

The group offered the girls a broad opportunity for the development of positive relationships with authority figures and with their peers. The leader saw her role as keeping the discussion focused on the girls' immediate problems, controlling impulses, acting as mediator, and creating a growth-inducing atmosphere. In order to help them sustain the gains they had made and recognize that they would need help over a long period of time, not just during their active participation in the project, an after-school, biweekly discussion group was started during the girls' first week in regular school. The 18 girls in this group set up their own goals for these discussions—"to stay in school," "to avoid a second pregnancy," "to develop their personalities."

The leader's role changed with the mothers' group which also met biweekly. At their meetings she was

much more directive than with the adolescents, although she did encourage free discussions. The emphasis was on strengthening the woman's motherly role by fostering better self-understanding, building feelings of adequacy, and improving their communications with their daughters. She also helped the plan special activities such as parties and outings with their daughters. Many of these socially isolated mothers developed firm friendships in the group.

Characteristics of the girls

Most of the girls we served had already repeated one or more grades of school and were functioning academically on a level 2 to 4 years below normal expectations. Many described themselves as having few friends and lacking physical attractiveness, talent, and skill. In general, they were poorly socialized, immature, and impulse-ridden, and had developed few inner controls. They often used aggressive behavior as a defense against feelings of emotional deprivation, dependency, inadequacy, low self-esteem, and isolation from others.

The initial response of the girl's mother to her pregnancy usually reflected high anxiety, stress, and hyperactivity. Feelings of guilt were projected onto the girl or to factors outside of the family. The pregnancy was viewed as an assault upon the family and, for a temporary period at least, it seemed to mobilize the family to better organization. However, the apparent ability of the family to cope with the problems it presented was usually only superficial. Putting up a facade is the mechanism some families have historically used to maintain themselves in the face of continuous and multiple slaughters on every aspect of their daily lives. We saw in mothers a deep sense of disappointment—daughters for whom they had wanted a better life were now caught in the same bind as themselves.

The majority of the girls exhibited a noticeable regression to more infantile and dependent behavior. They said their sexual experience was no different from that of other girls their age and saw themselves as "victims of circumstances" or were generally puzzled that the pregnancy could have occurred. But their feelings of guilt were manifested through somatic complaints and through projecting responsibility for their condition on others. Many had difficulty in accepting their pregnancy as fact and tried to carry on activities incompatible with this condition. After they had given birth they were usually able to talk about themselves more realistically.

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I DON'T UNDERSTAND

by MAMIE (a teenage unmarried pregnant girl)

I don't understand why she [Mother] is always on my back,

Because I always try to stay out of her path.

She has a he and treats him like a king, but among other things, I think he is a scream.

She makes his lunch and fixes his bed; it's a wonder she doesn't fix his head.

I don't understand why she thinks I'm so fast

Because I always try to stay in my path.

She makes me glad—she makes me sad

I wonder why she is always mad?

She loves her son very much, but her daughter is such a slut.

I tell her she should treat us equal, but you think that helps?

She'd surely be ready to belt.

Of all I said, I think she's grand—

I just want to say—I don't understand!

degree of conflict and emotional deprivation experienced by the girl, particularly in her relationship to her mother. Girls often described feelingly how "nice" a boy had been to them and how affectionate, even when they knew he had been involved with other girls at the same time.

We interviewed some of the fathers of the expected babies. Few expressed any responsible interest in the girl's state of well-being, in participating in any planning in her behalf, or in continuing the relationship. Although the girls were unhappy and angry over such abandonment, they continued to engage in fantasies about the positive role the father would assume in their own and their child's life. Most of them had such a strong need for love and affection that they either attempted to continue a relationship with their baby's father or began seeing a new boy.

How they saw themselves

The following excerpts from a record of a group meeting conducted by one of the project's staff social workers, Dolores Exum, reveal something of the girls' self-image.

... Ann started the meeting by asking me a direct question about whether I had had sexual relations as a teenager. Joao, Sylvia, and Mamie joined in a chorus, demanding that I answer. Susie and Carrie said that they wanted to be "counted out"—meaning that they were not pushing to have me answer.

I said I wondered why they asked this question. Joao said I was their "idol"—they did not act like it, but I had a lot of influence on them. Ann spoke of her South Shore friends (middle-class neighborhood). They live in houses and go to college; all the girls "put on airs." They take pride in being "virgins." She suspected that I was like the "South Shore kids." Some might be true virgins, but she suspected some knew a lot about birth control. . . .

Since Ann brought up the question, I asked her if she had anything else in mind. She said she wondered whether it were possible to grow into adulthood without having sexual relations. The group thought it was possible, and they talked about what the teachers had said about their teen years. Susie mentioned that Mrs. A said she had grown up in a neighborhood like the ones in which they lived and "she had not given in." Frances and Marie thought it was "luck" that enabled a girl to avoid being seduced. Marie said she would never go steady again. . . .

I talked about my feeling that each girl had within her certain capabilities and strengths which she could use to make for herself the kind of life she wanted. . . . I said I was certain the girls in South Shore had to control their sexual urges, too. Perhaps some know more about birth control because they think it is a good idea to postpone motherhood until they are older and married. I used several examples of thoughts the girls themselves had expressed about how to avoid intimacy in dating relationships.

Mamie said it was time to turn to other matters. . . . She

lly and to express feelings of guilt, frustration, and unreadiness to assume motherhood.

Most of the girls expressed a desire to keep their babies. But they were rarely able to participate in discussions geared to planning realistically for the child. Many of them seemed to see the baby's identity as being inseparable from their own. They needed to turn to their mothers for direction.

Hence, the mother's own feelings and attitudes, reflecting many complex pressures, bore strongly on the plans for the child. Among these pressures were a strong cultural sense of obligation to care for one's son; the mother's sense of guilt about her own sexual behavior which had produced a child out of wedlock; and her identification with her daughter's situation. Frequently, a girl's mother regarded keeping the baby as a maturing experience for her daughter, or as a means of controlling her future activities, particularly with respect to any future sexual behavior. Some mothers also indulged in the fantasy that the new baby was providing them with a second chance to perform the motherhood role effectively, a role in which they felt they had failed with their own children.

The girl's relationship to the baby's father varied with the girl—ranging from a casual encounter to an intense relationship of long duration. The intensity of the relationship seemed to be associated with the

said she had a poem she wanted to read to the group. [See page 175.]

Given made a depreciatory remark about Mamie's poem . . . (but) Carrie and Susie said the poem was "nice."

Mamie suggested writing down things you are unhappy about as a way of "getting things off your chest." Donna said it was "too bad that girls could not talk to their mothers." The only time she was able to feel close to her mother was when she was "high on the roof." Carrie explained that this meant "feeling good from alcohol." Her mother was like that too.

There was an exchange between Mamie, Donna, Carrie, and Ann about being "dragged down" by depreciatory remarks and how their relationship had become more strained with their mothers since their pregnancies.

I suggested that what they had been saying had something to do with why a girl seeks closeness with a boy, and that sometimes a baby was a by-product, which only intensified a girl's difficulties.

The meeting had been extended past our regular hour. I suggested that we think about what we would like to discuss in our next meeting. . . . As there were no comments, I suggested birth control. There was considerable enthusiasm.

Plans ahead

As a result of its 3 years of experience in this pilot project, the Board of Education, in February 1966, established the first of several schools planned for unwed pregnant girls in Chicago. Known as the Family Living Center, the school is located in a modern, well-equipped, educational building of a church and is well suited for an academic and vocational training program. The school can accommodate 255 girls at one time, and it is expected that 450 girls will be served in it during a calendar year. As of June 30, 1966, 151 girls (91 in high school and 60 in elementary school) were attending the new school. Thirty of the elementary schoolgirls in this group were transferred from the original project school. They, along with the others, are receiving health services, as well as some of the additional services described in the demonstration program.

On the basis of the project's demonstration that comprehensive services for the adolescent unwed mother can be provided and effectively used through creative cooperative programing, expansion of the medical, social welfare, and mental health services of the Community Services Project is about to be launched, under a contractual arrangement between the Chicago Board of Health, the Illinois State Department of Public Health, and the Florence Crittenton Association of America.

The new services will be coordinated with the expanding educational services offered by the Board

of Education. Together the two programs should go far toward meeting the needs of pregnant school-age girls in Chicago. They will be focused on girls remaining in their own homes during pregnancy who are isolated from the mainstream of urban living and who come from culturally and economically disadvantaged groups, including Appalachian white people, Negroes, Indians, and Puerto Ricans.

The staff of the Community Services Project will be enlarged to include additional social workers (male and female), psychiatrists, an obstetrician, full-time nurse, and a nutritionist. In addition to complete prenatal and postnatal care for the girl and comprehensive health care for their babies, a network of other services will be offered the girl, their parents, and the putative fathers. These services will be given not only during the girls' pregnancy, but also on a continuing basis thereafter, if needed.

We will also continue recently introduced weekly discussion meetings with the teaching staff, led by staff psychiatrist. These meetings have not only helped teachers to increase their understanding of the emotional and other factors operating in the girls' situation, but have also increased their ability to make the best use of themselves in their roles as teachers. Similar discussions will also be carried out for members of other disciplines on the staff. Regular meetings of the entire staff will also be continued.

Our experience has taught us that comprehensive services necessary for this type of program require the use of many disciplines. It is, therefore, fundamental that staff members function as a team to share their individual training and skills for the improvement of the girls' complete well-being.

There is also a need for all professional disciplines to take a long hard look at the way in which they approach persons who come from other than middle and upper class socioeconomic groups. The time has long past when we can afford to see these people as "untreatable," "poorly motivated," and "impervious to standards of socially acceptable behavior." Rather, we must assume an aggressive reaching-out role with them. The problem is not one of having to adapt the clients to the techniques and expectations of the various helping professions, but rather, of gearng our approaches to the clients' or patients' special needs and problems.

¹ Close, Kathryn: Giving babies a healthy start in life. *Children*, September-October 1965.

THE PREVENTION OF ORAL DISEASES IN PRESCHOOL CHILDREN

WILLIAM E. BROWN

● In spite of serious efforts to educate the American public, a large segment of the population still holds to the belief that primary (baby) teeth are relatively unimportant because sooner or later they will be replaced. Hence, they do not attempt to develop patterns of good dental health care in their children until, in many instances, it is too late, and they do not see the importance of dental programs for young children whose families cannot pay for private care. Actually, sound standards of dental health care should be established as early as the beginning of the calcification of teeth, that is, by 5 months in utero, and should be continued throughout childhood.

Dental health is not an isolated part of health, but a part of total health, and therefore representatives of many professional disciplines are involved in its preventive aspects—for example, pediatricians, public health nurses, and nutritionists. When dental health is seriously impaired, the child's physical and emotional health may also be endangered. Moreover, good dental care in childhood usually will prevent the need for dentures in an adult.

This article will outline a program to help prevent oral diseases in preschool children; and since preventive efforts cannot always be completely effective, it will also discuss current concepts of treatment from the dentist's point of view. Oral diseases encompass

a variety of problems, including dental caries (cavities), periodontal diseases (diseases of the gums and supporting bones), malocclusion (crooked teeth), injuries to teeth, and developmental abnormalities.

Dental Caries

Fluorides. Dental caries is one of the most prevalent diseases known to man. In fact, only about 5 percent of Americans are caries-free; and children are the most susceptible. Many sound preventive measures are available, the fluoridation of communal water supplies being the most effective. One part per million of a fluoride in drinking water will prevent up to 65 percent of all cavities. The effectiveness and safety of this preventive measure have been proved beyond all question.¹

It is little short of a national tragedy that only one-fourth of our population enjoys the benefits of this outstanding public health measure. The day is not far off, we hope, when the majority will shrug off the half-truths of the few but vocal people who oppose fluoridation and will accept the guidance of most health specialists who urge the addition of a fluoride to all community water supplies. The reduction in pain and cost and the preservation of good appearance attributable to this preventive measure are inestimable.

Where fluoride in drinking water is unavailable, fluoride supplements, drops or tablets, can provide a reasonable substitute. Many commercial fluoride supplements are available and can be secured by prescription through any dentist. Children should be placed on a fluoride supplement from birth until 8 years of age, at which time all of the permanent teeth (except third molars) are calcified.

In the absence of fluoride in drinking water or fluoride supplements, the topical application of a fluoride solution (swabbing fluoride on teeth), at appropriate intervals, is the next best precaution. The procedure is simple, painless, and inexpensive. It is available in most private dental offices. Moreover, many community groups have developed topical fluoride programs to provide this service on a mass basis.

Several caries-preventing toothpastes (usually containing a fluoride compound) have been recognized as helpful by the Council on Therapeutics of the American Dental Association. Because reports on the effectiveness of these dentifrices vary, their value is not fully determined. Yet, it seems logical to recommend their use.

Carbohydrates. Carbohydrates, especially sugar, play a highly significant role in the production of cavities. The more sugar a caries-susceptible person eats the more cavities he will get. Certain bacteria present in the mouths of most people convert sugar to an acid which decalcifies the enamel of the teeth, and this initiates the formation of cavities. The process takes place in the mouth shortly after the sugar is taken in and is not in any way contingent on sugar in the blood stream. Between-meal snacking on foods with high sugar content is more damaging than the same foods eaten at regular meal times. A caries-susceptible person should partake of a minimum of candy, pastries, sugar-containing soft drinks, ice cream, chewing gum, and chocolate milk.

Since most children are snackers, regardless of the consequences, efforts should be made to supply them with noncariogenic snacks such as carrot and celery sticks. Brushing the teeth immediately after eating should be encouraged to scrub away the cariogenic materials.

Young children who have the habit of taking a nursing bottle of milk to bed may develop rampant caries. The milk tends to bathe the teeth for long periods of time, while the child sleeps, and the lactose in the milk may be destructive to the teeth of caries-susceptible children. Fortunately, by the time children have teeth they are likely to be on whole milk without sugar added. However, since there is disagreement among nutritional researchers whether the lactose in milk is productive of cavities, and hence whether milk without sugar added can be harmful to the teeth, the habit of taking a bottle to bed should be discouraged.

Short-term low carbohydrate diets are frequently advised for both children and adults who are highly susceptible to caries. However, such a diet must be controlled carefully under a dentist's supervision and should be advised only on consultation with the child's physician and when the family is seriously

motivated to cooperate. Such a diet sharply reduces the acid-producing bacteria in the mouth. Even when it is discontinued, the number of bacteria remains low for extended periods.

Treatment of Cavities. All children should visit a dentist by the time they are 30 to 36 months old for a routine examination and oral prophylaxis. Cavities, if present, will usually be few in number and small in size. They should be treated promptly. If untreated, they will increase in size and eventually invade the nerve of the tooth. Toothache, infection, and the need for extraction of the tooth will result.

If a primary (baby) tooth is lost prematurely, particularly a molar, the space left will gradually close because of the shifting and tipping of the adjacent teeth. This closure of space will often block the normal eruption of the succeeding permanent tooth several years later, resulting in a serious malocclusion. Although space-maintaining appliances can prevent space closures, their use is often difficult in preschool children. They are difficult to fabricate successfully and must be kept in service for many years until the permanent teeth erupt.

The first permanent (6-year-old) molars usually start to erupt by the 6th year. They may erupt, however, as early as 4 years or as late as 8 years. The tooth erupts behind the last primary molar in the arch, and no primary tooth is lost in the process. Parents often mistake the first permanent molars for late erupting primary teeth and are little concerned about their well-being. Because of the deep fissures in the biting surfaces, these permanent teeth often develop cavities very quickly. If these cavities are not treated and the teeth extracted, the entire future of the child's dental health is in serious jeopardy. Even comprehensive orthodontic care (straightening) may not completely solve the problem. The breakdown of an adult dentition may stem from this very early problem.

No longer are there valid reasons for children to be fearful of dental treatment. It is rarely uncomfortable, due to good, easily administered, local anesthetics and instruments operated with a feather-like touch. If the child is taken to the dentist early before the existence of serious problems, he can be introduced to dental care gracefully, and the dental confidence has the opportunity to gain the child's confidence. Once confidence has been won, it generally persists for life. After a child's dental needs have been cared for, it is extremely important that he return

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or periodic reexaminations and maintenance care. Regular visits minimize treatment needs and cost.

X-rays of a child's mouth are usually required for thorough diagnosis. They are necessary to detect cavities between the teeth, to detect root-end infection, to determine significant patterns of growth, and to detect extra or congenitally missing teeth, the knowledge of the presence or absence of which is important in planning properly for the child's dental future. Modern X-ray machines, when properly calibrated, and fast films make this diagnostic service safe even for young children.

Periodontal diseases

Diseases of the gums and the bones supporting the teeth are rare in preschool children. Diseases of the gums become more frequent in school-age children, and in adults they are the most common cause of the loss of teeth. Habits of good home care of the teeth and gums should be established early in life. In fact, toothbrushing should begin as soon as the first primary teeth erupt, as early as 6 to 8 months of age. Of course, at this early age the parent will brush the child's teeth. As soon as the child develops adequate motor control, he should participate in the toothbrushing routine under the guidance of the parent. With persistent instruction, he will usually develop firmly entrenched toothbrushing habits. Good brushing habits, coupled with a periodic professional oral prophylaxis, should assure continued health of the supporting tissues.

The preschool child should possess two small-size toothbrushes and use them alternately. They should be replaced when they are worn and too soft. Electric toothbrushes may encourage more regular brushing because of their novelty. Recent studies, however, indicate little difference in effectiveness between the electric and the hand brush. Electric brushes can be advantageous for youngsters lacking in motor coordination. A caries-preventing toothpaste should always be used. Dental floss should not be used by preschool children because it must be used gently and can irritate soft tissues when used carelessly. Mouthwashes have little value.

Malocclusions

Most malocclusions (crooked teeth) are hereditary. Some, however, result from environmental factors. The premature loss of primary teeth is one of these factors. Persistent thumb- or finger-sucking habits



X-rays showing a severe malocclusion with teeth blocked out of the arch because of premature loss of primary teeth. This could have been prevented by filling the primary teeth.

are additional factors which may result in serious malocclusions.

Thumb-sucking until age 2 is generally considered normal, and it is a common habit. However, if the habit persists beyond age 2, it may result in a malocclusion, depending on the type of natural occlusion and the frequency and intensity of the habit. The habit disappears naturally in many children; in others it may continue for many years. The reasons for the differences in duration are not known precisely, but emotional security and parental attitudes may be partly responsible. In some children, the only reason for the prolonged habit may be lack of incentive to break it.

There is no "right" time to break all thumb-sucking habits; although the sooner it is done the better. If the habit is overcome before the permanent teeth start to erupt, any resultant malocclusion may be self-correcting. Habits which continue until after the permanent teeth begin to erupt often result in malocclusions which require orthodontic correction.

The dentist can serve as a persuasive counselor and may be able to influence the child to give up the habit, by showing him its ill-effects through models and photographs of malocclusions. If he persists, the parents should be advised to discuss the problem with their pediatrician or family physician. The management of the habit in children with underlying emotional problems may be very complex, for the elimination of one habit may result in the substitution of another even more undesirable.

Pacifiers for very young children have been suggested frequently as a substitute for the thumb. The efficacy of pacifiers is not well known. They, like the thumb, can cause protrusion of the upper front teeth. However, pacifiers are usually discarded earlier than the thumb-sucking habit, making self-correction of the malocclusion more likely.

Injuries and staining

Preschool children often receive blows to front teeth from simple falls or flying objects. Such injuries can result in discoloration of teeth and death of the nerves. Discoloration in itself is of little consequence, but nerve death is significant and often results in infection and the necessity for extracting the tooth. Any child receiving an injury which produces displacement, fracture, or discoloration of teeth should be examined promptly by the dentist.

The early loss of a primary front tooth is relatively unimportant since spaces rarely close in this segment of the dental arch. Usually the greatest problem is the concern of the parent who is disturbed by the child's toothless smile. The artificial replacement of a missing front primary tooth is difficult and usually not worth the effort. When several front teeth have been lost, however, replacement may be necessary to prevent collapse of the lip and speech impairment.

Intrinsic, permanent staining of primary teeth has many causes. Tetracycline is one. Tetracycline, an antibiotic drug sometimes used to treat upper respiratory and middle ear infections in children, may produce permanent, disfiguring staining in primary and permanent teeth. When the drug is used for short periods and infrequently, the staining may be relatively minor. When it is used frequently and for prolonged periods, the staining may be severe, and the teeth may even become misshapen. There is no treatment for these teeth short of covering them with jacket-type crowns. Since tetracycline can stain teeth throughout the period of calcification, it should be avoided, whenever possible, by pregnant women after 5 months of gestation and not given to children before they are 8 years of age. Since there are several other drugs with similar or greater effectiveness, avoiding tetracycline should create no serious problems.

Last year, only 40 percent of the people in the United States visited a dentist at least once. Even

fewer received complete care. This is an appalling low percentage in a society as affluent as ours. Programs to educate the public about oral health care and to motivate people to seek professional service have obviously not been highly successful.

However, the high cost of good dental care undoubtedly another factor deterring many families—especially those with the lowest income—from securing such care for their children. Up to now few programs for promoting the health of children of low-income families have included dental service. Medical services are running far behind the need of these children, and dental services are running even farther behind. Many of the dental services which have been made available provide only for emergencies, chiefly extractions.

An encouraging note is the specific mention of dental care in the new health programs authorized under the 1965 amendments to the Social Security Act—in Title XIX, which provides for grants to the States for medical and remedial services for certain families and individuals whose financial resources are insufficient to meet the cost of care, and in the new section of Title V (sec. 532), which provides for special project grants for the comprehensive health care of preschool and school-age children in low-income areas.

In view of the potential increase in demand for dental care stimulated by these Federal programs, the American Dental Association is formulating a program to provide guidelines for dental care for all the Nation's children. This will be presented to the Association's House of Delegates at its annual meeting in November 1966. Questions of manpower requirements, facilities, cost, and priorities for care are being explored in the preparation of this program. The purpose is to provide direction and focus in coordinating plans for dental care so that good care may be available to everyone.

The importance of early and regular dental care cannot be overemphasized. The standards of dental health are established early in life, even before the child is born. Good habits developed in childhood will lead to good dental health in adulthood. They can be encouraged by physicians and public health nurses as well as by dentists. The goal, the elimination of all dental disease—a distant one to be sure—is well worth striving to achieve.

¹ Ast, David B.: Prophylactic against caries. *Children*, November 1956.

1. a look at what they do

VAN G. HROMADKA

Do child-care workers in children's institutions need more formal training for their jobs than they are getting, and, if they do, what kind?

In an effort to answer these questions, the Jewish Board of Guardians, a voluntary children's service agency in New York City, recently undertook an inquiry, with the support of the National Institute of Mental Health, into what the child-care task actually involves, in a selected sample of children's institutions in the Mid-Atlantic region, and how child-care workers are equipped to carry it out.¹ There were both encouraging and discouraging aspects of the findings.

The most encouraging aspects were that, taken together, the tasks being carried out by the child-care workers comprise the creation and management of a reasonably secure and comfortable living experience for the child, with a definite therapeutic purpose; and that child-care workers, administrators, and clinical staff alike recognize the need for revision as well as extension of current training efforts to carry out these tasks truly effectively.

The most discouraging aspect was that in no institution were the workers trained sufficiently for what was expected of them. In many instances they were put to work without any basic understanding of their task.

The 12 institutions studied were selected from 238 in Connecticut, New Jersey, New York, and Pennsylvania which responded to a questionnaire sent to all the agencies in these States providing residential services for children. A major basis for selection was that the institution had less than 30 percent of its population under clinical treatment for emotional

disturbance and a staff ratio of no more than 25 children for each therapist and child-care worker. Under seven other criteria, agencies selected for the study all (1) included some emotionally disturbed children; (2) had at least one full-time psychologist, psychiatrist, or psychiatric social worker on the staff; (3) cared for not less than 12 children; (4) cared for some children between the ages of 6 and 16; (5) cared for children on a long-term basis; (6) provided children with residential care on a 24-hour day, 7-day week basis; and (7) were not hospitals, maternity homes, or institutions for mentally retarded or physically handicapped children.

In all, 36 institutions met all the qualifications, and one-third of these were chosen for the inquiry with careful attention to achieving a sample covering a full range in structure and philosophy.

From these 12 institutions, 24 child-care workers were selected by their immediate supervisors and the heads of the participating agencies for interviewing and observation by the study's staff. Half these child-care workers were men and half were women. Although "average" workers were requested, the administrators' participation in the selection probably resulted in the inclusion of the better workers.

All participating child-care workers were assured that they could feel free to express unpopular views because the views they expressed in the interviews would be kept confidential and the participating agencies and staff would be identified by code number only. They were also told that the purpose of the inquiry was to bring about improvement in the status as well as services of child-care workers and that by participating in it they would be making a contribution toward this.

The inquiry proceeded through open-ended interviews with the child-care workers, their supervisors, and their agency administrators and through direct observation of the child-care workers at work. The purpose of the interviews was to obtain information on each worker's background, his personality, why he went into the child-care field, what kind of training he had had or was getting to prepare him for his job, how he was using the training he had had, what negative factors might be affecting his work, and his own and his superiors' opinions of his need for further training and knowledge. The work observation was focused on the volume and nature of the activities and responsibilities expected of the child-care worker and those he carried out, the ways he carried them out, the amount of decision-making power he had been given or had assumed, and the way he dealt with emotional interchanges with the children. It also noted the similarities and differences in the agencies' philosophies and practices in relation to the child-care worker's role and the quality of the attitudes of other staff members toward him.

Each child-care worker was observed for two periods: (1) in the morning from the time the children were awakened through breakfast; and (2) in the afternoon from the time the children returned from school through the evening meal. These two periods were chosen as the times when the child-care workers were in most direct contact with the children. The validity of the observer's impressions was upheld when tested against the scores made by the child-care workers on an instrument prepared with the help of three psychiatric social workers and three group workers. It asked the child-care workers what they would do to handle an angry and impulsive group of children who threaten to punish one member of the group because they suspect him of stealing an object of personal value from another member who happens to be the group's favorite. Desirable re-

sponses were to fall within the following work prescription:

- The child-care worker has to retain control of the situation.
- The worker has to act promptly.
- This is not a case for deciding whether to handle the immediate needs of one boy or those of the group; the individual and group level must be perceived at simultaneous levels of an organic situation.
- If the boy is guilty, this fact must be assessed and the boy held accountable; if not guilty, the group must be helped to accept this.

The child-care function

Seven basic areas of responsibility were common to all the child-care workers observed. These might be termed the "prototype" of residential child-care function where treatment and rehabilitation of the child are the objectives of institutionalization:

1. Participating personally in the planned, daily routine of group living, including awakening the children in the morning and putting them to bed at night, and—depending on the diagnosed degree of dependency of individual members of the group—supervising, guiding, and encouraging socially acceptable habits regarding body hygiene, personal grooming, toilet training, table manners, and dealings with others.
2. Supervising the provision of food, clean clothes and bedding, and other items and services needed to meet the requirements of reasonably comfortable and socially acceptable group living as well as the special needs of individual children as determined by their therapists.
3. Providing first aid and nursing care—under medical supervision—for the child who is injured or sick.
4. Providing and symbolizing security to the children by maintaining discipline and order in and around the living quarters and on outings as well, keeping the demands of individual children in balance with the needs of the group as a whole.
5. Participating with the children in both planned and casual recreation and other activities such as household chores and other work projects designed to promote a healthful experience for the children and to provide them with a meaningful and socially acceptable outlet for accumulated physical energy and pent-up emotions.
6. Stimulating the children to seek knowledge and orienting them toward the social norms which govern life both within and outside the institution.
7. Interpreting, facilitating, and enforcing the institution's policies and providing information to and consulting with other staff members about individual children.

In no institution did the child-care task consist

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solely of the activities in this "prototype" of the child-care function. The number of additional activities expected of the child-care worker ranged from 5 to 11 per institution. They fell into four main categories: (1) direct housekeeping; (2) special educative and guiding efforts; (3) broader involvement in psychological help; and (4) administrative management. In some places these additional activities were prescribed by institutional policy; in others they were not. Yet workers engaged in them were found in all institutions studied.

There were as many workers delinquent in carrying out the additional activities expected of them as there were workers who assumed such responsibilities on their own initiative and without prescription from the administration. Both the failure to perform to expectation and the voluntary assumption of responsibilities seemed determined by the worker's choice or ability, or both, rather than on-job prescription or policy enforcement. However, in contrast to the popular image of child-care workers, few of the workers in the study directly performed housekeeping chores.

More than one-half of the child-care workers' time was spent in meeting the psychosocial needs of the child. One-third of the workers' time was spent in meeting the children's physical needs, and the rest was absorbed in administrative duties.

The satisfaction of psychosocial needs, regarded in all 12 of the institutions as central to the child-care function, involved re-education of the individual child and intervention in the group living process. Study of the living process through observation showed an average of 15 different situations requiring a worker's attention over a 5-minute interval. This reflects the high pressure under which the child-care worker operates and his need for working techniques to help him deal with problems quickly and effectively.

The child-care workers' management of and intervention in the group living process were characterized by a unique systematized method, which could be identified as the child-care method. This involved psychosocial, enabling, educative, and authoritative behavior, applied differently in different situations: predominantly or supportively, alone or in combination, simultaneously or in succession.

These four types of behavior involve the following tasks:

- Psychosocial behavior—providing the warmth of companionship by physical presence, words, and other

demonstrations of "caring" to facilitate social and emotional comfort and growth.

- Enabling—providing leadership in the group's activities and manipulating the environment to maintain group balance or achieve a goal.

- Educative—instructing, guiding, demonstrating, and counseling to facilitate learning.

- Authoritative—enforcing discipline and responsibilities through physical presence and through controlling intervention, verbal or other.

These techniques are, of course, used by others engaged in working with children in institutions. The unique patterns in which these types of behavior are applied by child-care workers are illustrated in the box below.

Training needs

None of the child-care workers interviewed had received training before they entered employment. Two-thirds of those in the study had been assigned

TECHNIQUES USED BY CHILD-CARE WORKERS

in dealing with the needs of children living in a group

types of children's needs	techniques predominantly applied by child-care worker	order of reinforcing techniques
to belong	psychosocial behavior	enabling behavior
to be respected	enabling behavior	1. psychosocial behavior 2. educative behavior
to be protected	psychosocial behavior	1. authoritative behavior 2. educative behavior
to get along with others	authoritative behavior	1. psychosocial behavior 2. educative behavior
to further knowledge and skills	enabling behavior	1. educative behavior 2. authoritative behavior
to have satisfying constructive social experience	enabling behavior	psychosocial behavior

to groups of children when they first reported to work and were given little, if any, orientation to the job. While they all had continuous on-the-job supervision, it was largely confined to indoctrination in routines and policies of the institution. Only three of the institutions provided for intramural and extramural courses for on-the-job advancement of the child-care staff.

Thus, the only true source of training for the child-care workers was their supervisory experience. Yet in only 6 of the 12 institutions was the supervision provided by staffs specifically designated and trained in some manner to do the job. In the other institutions, the supervision was provided either by the casework supervisor or the administrator, whose schedules were heavily loaded with their own responsibilities.

In the institutions, the supervisor frequently was not available when needed and the supervision tended to be superficial and unrelated to the concrete situations which face the worker from day to day. Some of the workers spoke of being so discouraged with their supervision that they relied chiefly on their commonsense in dealing with the children—an indication that they had retreated from the learning process.

In both the on-the-job supervision and the special courses provided for child-care staff members, the child-care workers had important points in child development called to their attention, but were given no prescription for going about the tasks at hand. For example, they were given no instructions in how to observe, evaluate, and report on a child's functioning, nor in methods of psychological management of the individual child or of group intervention. They were encouraged to tolerate acting out and impulsive behavior on the part of the children, but were not told what measures they could use to secure order in the living units nor how they could help a child having an emotional outburst bring himself under control. They were taught that they could accomplish their task through their relationship with the child, but not how to apply this idea in dealing with many children making many different kinds of demands at the same time.

The supervisors maintained they themselves needed to learn a great deal more about the child-care process

before they could provide meaningful guidance and teaching experience to the child-care workers.

Some implications

Inadequate instructions can do more harm than good. They may not only confuse the worker and hamper his conscious use of the self, but may also further reinforce his emotional defenses and make him withdraw from further learning. Although the concepts of social work and psychiatry may help the child-care worker greatly in establishing his relationship with the child, the multiple aspects of the child-care worker's task and the forces which continuously interfere indicate that tools designed for use in an isolated treatment hour are insufficient for group living. While casework and group-work methods apply in specific treatment situations, they do not give prescriptions for the complexities of group living. With dozens of things demanding attention at the same time or in rapid succession, the child-care worker, by using techniques which help him deal with problems quickly, has been developing, without knowing it, a new disciplinary method.

The child-care method, of course, needs further conceptualization, refinement, and improvement, and it needs to be transcribed into units of work prescribable before it can become communicable and teachable. This calls for a collaborative effort on the part of institutional administrators and educational institutions to pull together and enlarge upon the present knowledge in child-care technology and to revise old training programs and formulate new ones looking to institutional child care as a distinct discipline with its own methods of functioning.

Training at two levels seems indicated: (1) basic training for child-care practitioners, and (2) advanced courses in child care for supervisors and other leaders in the child-care field. An imperative is to make basic training available and compulsory at the pre-entrance level of employment, not only for the sake of raising the status of the child-care worker, but also, and above all, to protect the children in care against abuse of experimentation by workers insufficiently prepared for their task.

² National Institute of Mental Health Grant No. MH-631-6.

2. a two-level training program

GUINEVERE S. CHAMBERS

GENEVIEVE W. FOSTER

Elsewhere in this issue of CHILDREN, Van G. Hromadka gives evidence of the need for training institutional child-care workers. [page 181.] He has also, in a past issue of this journal, deplored the inadequacy of child-care training programs in this country as compared with Europe, where a large proportion of child-care workers are graduates of 2-year courses in child care.¹ Child-care workers as referred to in his earlier article—persons—sometimes called houseparents or counsellors—who assume full- or part-time care of groups of children.

We agree with Dr. Hromadka that there is insufficient training of child-care workers in this country.

We are, however, in a position to describe a university program for training child-care workers which has been in operation since 1954 and which offers training at two levels, the one leading to a degree of master of science in child development and child care, and the other to a certificate in child care. Both programs require the students' full-time participation for at least 2 years. The programs are offered in the Child Psychiatry Service of the Department of Psychiatry in the School of Medicine, University of Pittsburgh. They grew out of an awareness within the Department of the importance of the emotional health of children of understanding the skill in those who care for them; hence, the establishment of these programs in the medical school, although most other university courses in this country in the study and care of children are offered through schools of social work or home economics departments.

Some comments about our experience may be of help to others who are concerned with developing programs to train persons for caring for children.

The first program established was that leading to the master's degree. This was initially planned to provide training for persons who would care for normal or deviant children in residential or day-care centers. It soon became apparent, however, that agencies which were employing the program's graduates regarded them as too expensive for use in the daily care of children and were assigning them instead to supervisory, administrative, or teaching positions, except in a few instances where they were assigned as leaders of otherwise untrained child-care teams. Therefore, to prepare persons for child care who would not expect higher level positions or salaries, the Department, in 1963, with the help of a grant from the National Institute of Mental Health,² initiated its 2-year course for high school graduates. This course does not carry university credit but leads to a certificate in child care.

The M.S. program

In the beginning of the master's program, the following principles were laid down:

- Study of the normal child to precede that of the pathological child.
- Study of younger children to precede that of older children.
- Practical and theoretical aspects of a given subject to be taught concurrently.

• Emotional and intellectual, biological and sociological aspects of child development to receive concurrent and balanced consideration.

Thus the student is taught that, "a child is always a child, regardless of his personal handicap or living circumstances," as Dr. Hromadka has recommended.¹

In the graduate program, students who are planning to work with normal children and those planning to work with children who have special problems take most of their courses and also their early practicum (field work) training as a group, separating only for the later practica and for certain advanced courses, such as advanced psychopathology. Specialists in normal child development make up an impressive portion of the rather small faculty. This includes representatives from the disciplines of psychiatry, psychology, anthropology, sociology, social work, pediatric nursing, and education.

Training in the observation of children and in the understanding of these observations is started in the first weeks and continued throughout graduate study. Emphasis is on the importance of interpersonal relationship and on ways of using it in communication with the individual child and with one's fellow workers; and on the dynamics of groups and ways of using understanding of the interplay of individual and group behavior for the benefit of the children. The student is also taught to plan activities for the educational and emotional growth of the children, not just to keep them busy.

Theory and observation

The curriculum leading to the master's degree requires five or six trimesters of full-time work. In addition to passing his theoretical courses and practica the student must demonstrate a competence in a foreign language, pass a comprehensive examination, and write a thesis based on a small research project. (The foreign language requirement is included since it is a university requirement for a master's of science degree.) The heart of the educational effort, however, is the interweaving of the didactic courses with the practica in such a way that the student not only learns at the theoretical level, but also through observation and practice.

Thus the student entering in the fall and intending to go into some form of child care finds himself taking, first of all, an intensive course in the development of the preschool child, attending the nursery school of the Child Study Center one morning a week

as an assistant to one of the teachers, and participating in the weekly staff conferences at the school. From the beginning he makes written observations which are criticized by his teacher. About this process a student has commented, "I will observe a child action and see one thing in it, and then Miss B (the teacher) can point out five more that I didn't see."

In this first trimester, the student is introduced to research method, and he takes two courses which he selects from these: a survey of child-care agencies including field trips; a study of the cultural and familial influences on children; an introduction to testing and interviewing techniques; or, occasionally a relevant course in another part of the university.

In the second trimester, the student moves on to course on the school-age child. His field placement at this time is usually as an assistant to club group leaders after school hours for children on whom there is already an accumulation of data because they were formerly in the nursery school and whose further development can thus be watched with understanding and interest. The student is also introduced to a study of group dynamics in a group of his fellow students whose task is to learn to understand their own interactions. He also takes an elementary course in psychopathology, with a practicum consisting of brief weekly observation of, and play interaction with, emotionally disturbed children.

In the third trimester the graduate student majoring in child care is required to take a course in advanced psychopathology; he may also take a course in adolescent development. At this time he must begin to specialize, and he has his first practicum in the field of his choice 3 days a week. Until recently most of the students who were not training to work with normal children and their families elected to work with emotionally disturbed children and were placed for field work in residential or day-time treatment centers. Because some students now plan to specialize in the care of children with other problems such as mental retardation, physical handicaps, cultural deprivation, other field placements are being devised; and persons with special understanding of these handicaps are being recruited for the faculty.

In the fourth trimester the graduate student is engaged in his most intensive field placement, usually 4 days a week. At this time he may take the comprehensive examination on the whole field of study, and if he passes, he can use the fifth, and perhaps the sixth, trimester to write his thesis and take whatever courses he wishes from other departments.

In actual practice, few students complete the fi

trimesters of the course in the manner outlined, though most of them eventually finish the work for the master's degree. The demand for trained workers in the field of child care is so great that many students take responsible positions while they are still in the final stages of thesis writing.

Some of the program's graduates are now in charge of groups of normal children in day-care centers, nursery schools, community centers, or centers for the cultural enrichment of preschool children set up under Project Head Start, or in administrative or staff training positions in such centers. Others are counselors, program directors, or unit coordinators in day-care or residential centers for emotionally disturbed or delinquent children. Others are teaching child development or child care at the graduate, undergraduate, or junior college level.

This shouldering of responsibility before the academic task is fully finished is not wholly desirable from the student's point of view, but in a new profession faced with community need which so far outstrips the supply of prepared persons, it is a fact of life. Students in the program at least have the security of knowing that there will be jobs for all. The faculty members, on their side, know that they just not recommend anyone for a job who they do not feel sure has the ability to grow on the job.

the certificate program

The same community need assures positions for holders of the certificate in child care. These child-care workers become members of the teams giving actual care to children. They work in the same centers in which the graduates of the master's program are employed and hold such positions as assistants to the teacher in nursery schools or day-care centers, or in preschool groups conducted under the Economic Opportunity Act. They work as attendants or aides in day-care centers for emotionally disturbed children and in a State school and hospital for starded and disturbed children. Some work inelters for neglected and dependent children, and some in a day-care center for delinquents and emotionally disturbed adolescents. These certificate holders do not expect to attain high salaries, but they do start to work at higher salaries than untrained workers.

For the certificate students the training also comprises a 2-year program. The first year, composed of trimesters, involves a combination of lectures, discussions, and field work. The major part of the stu-

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W. Foster was until recently her associate as an assistant professor. For 3 years she directed the Technoma Workshop for Emotionally Disturbed Adolescents in Pittsburgh.

dent's time is taken up with supervised field work—one 14-week placement in an agency caring for normal children and two in agencies caring for deviant children. The field work is supplemented by two weekly meetings with faculty members. In one of these, the instruction is didactic—a lecture-discussion on some aspect of child development or child care. In the other, through guided group discussion focused on problems of communication and interaction, the students are encouraged to bring up problems they encounter in their field placements.

In the second year, the students are placed in internships—paid positions where they are under the supervision of the agency which employs them, but are also in frequent touch with the program's faculty, returning to the university for individual and group discussions on a scheduled basis every other week.

The certificate students do not, of course, receive as intensive theoretical training as the graduate students, but they too are expected to become keen observers of children and to learn from their observations. They too make written reports of their observations which are criticized by faculty members. By the time they graduate, they are expected to know what is normal behavior in children at different stages of development and to understand some of its meaning; to know how play and other activities contribute to growth; and to be able to provide opportunities and materials for growth-inducing activities. They are also expected to know how to respond therapeutically, rather than moralistically, to deviant behavior.

Certificate students do not study group dynamics as such, but they are taught enough about the behavior of children in groups to understand what is going on in a group of children and to recognize that the adult can sometimes influence the group constructively. They are expected to be able to communicate observations, ideas, and feelings to their co-workers and supervisors in the agency and to understand

something of their own and other people's motivations, so that they can avoid some of the difficulties that arise when people work closely together.

As now operating, the graduate program takes in about 10 new students each year and the certificate program about 18 new students. Candidates for both study programs are selected on the basis of individual interviews, a review of college or high school transcripts, and references secured from persons familiar with the applicants' previous relations with children. In all cases, the faculty admissions committee must be convinced that the candidate has sufficient warmth and ability to relate to children and sufficient motivation to undergo arduous training and to meet the demands of a responsible job. Intelligence is, of course, a requirement, but not the only one, for some very bright persons are unfitted for child-care work. Intelligence in a child-care worker must be accompanied by an awareness of his own feelings and sensitivity and responsiveness to others.

Perhaps the most important tool used in the selection of candidates is the intuitive appraisal of the candidates' potential by members of the teaching staff. Faculty interviewers learn to be alert for the too brittle front that might crack on contact with the primitive behavior of children, for the thinly veiled hostility that might make collaboration with team members—as well as contact with children—too difficult, and for signs of emotional deprivation severe enough to prevent applicants from giving emotional warmth.

Actually, applicants with such adverse qualities are rare. Many people have the ability to work with children, and few who reach the point of making formal application need be turned away for reasons other than lack of space in the program.

Student development

The curricula described here are the bare bones of the child-care worker's education. They are the means whereby the worker acquires the knowledge that will be necessary for his future occupation while he practices the tasks of child care and develops skill. Concurrently, however, the student is helped to undergo a process of personal development, different for each individual, which involves a deepening of his understanding of himself and of others, in interaction with children, colleagues, and supervisors.

Working as a member of a team caring for children can tax a worker to the utmost. The more disturbed or delinquent the children, the more difficult their

behavior, the more the worker finds his own inadaptability coming to the fore. In the stress of work with deviant children, the anger, anxiety, and rigidity the worker would like to conceal tend to come painfully into the open, so that each team member has much to accept and to forgive in himself and in everyone else. As the students learn to understand this, their understanding of themselves, of the children, and of other team members increases. Students have remarked about how their understanding of individual children has helped put their own childhood in perspective and has sharpened their insight into the reasons they are the kind of adults they are.

This encouragement of the process of maturation in the student is not provided as a therapeutic intervention in the student's life, but as an opportunity for natural growth and unfolding. However, students who feel the need for psychotherapy are referred to psychiatrists, sometimes to the Pittsburgh Psychoanalytic Institute. Such psychiatric help is more readily available in a training center for psychiatrists than it would be elsewhere. In a student body that at first numbered about 10 and now numbers about 30, an average of 1 student a year has either been helped to find psychiatric help or has been advised to withdraw from the program for psychiatric reasons.

Every student in each program has a faculty advisor. Within the programs, practice has changed somewhat from time to time as to the closeness an intensity expected in the student-advisor relationship. The present philosophy of the teaching staff is, however, that the experience the student has within the whole faculty-student group, rather than just his relationship to his advisor, is what helps him grow. He may, of course, see a good deal of his advisor, or of some other faculty member, at certain periods in his course of study. Emotionally, and intellectually, he will get something from one person and something from another. However, the give-and-take among the students is also important; they often acquire from each other qualities that no faculty member could give him. The climate of the student group is exceedingly meaningful to many students.

The sort of continuous therapeutic interaction that marks the relationship between worker and supervisor in the inservice training in some treatment centers is not encouraged in these programs, nor would it be appropriate or desirable. The group climate in which everyone is constantly getting behind everyone else's defenses, calling attention to the other's uncon-

cious manifestations of anxiety or hostility, is also absent. A proper reserve and a normal courtesy are the rule. The group dynamics course and the constant discussions of interaction in classes and field placements serve to make the students alert to the meaning of their own and others' behavior. Though it is rarely necessary, the faculty advisor will call the student's attention to some behavioral habit if it interferes with his relation to others. The student has better maintains his autonomy, does not find himself a partner in dominance-submission games with faculty and fellow students, does not regress to a point where leaving the program at the end of his last term becomes too much of an ordeal. Growth appears to be promoted, not retarded, by this conservative policy.

Group dynamics

Within the philosophy of this plan, however, has been the cautious experimentation in the last 2 years with exposing all students to the group dynamics course. This experimentation began in the graduate curriculum with the substitution of a course in which the class itself is the object of study for an elective didactic course in group process. The new course was introduced in the winter term of 1964-65 and, though nominally elective, was taken by all first-year students, some second-year students, and even some staff members of the Western State Psychiatric Hospital. The experiment proved to be a rather shaking experience for some of the participants, but not unpleasantly severe. It seemed so valuable for increasing the students' insight into their own and others' behavior that it may become a regular part of the curriculum.

During the past academic year, a similar experiment was tried out with the incoming class of certificate students. The entire class of students, with its instructor, constituted a "home base group," the members of which, in weekly meetings, were gradually made aware of their own interaction as they discussed the experiences they had had in their field placements. This does not mean that individual conferences were denied the students when needed, but that most group meetings also met individual needs.

When the graduate program was new, prospective students asked members of the admissions committee whether they were sure there would be positions available when they finished school. To this question the committee members could only reply that they had every confidence that jobs would be available. Nowadays the question is seldom asked, because the

need is so evident on every side. Some of the positions into which trained child-care workers are going did not exist 5 or 6 years ago, for instance, those available under Project Head Start.

Child-care workers have, however, sometimes experienced difficulty in defining their professional identity, because theirs is a new sort of training. The task for which they are especially prepared has been carried out in the past, sometimes well, sometimes less than well, under other titles by workers who may have been highly trained, but for other types of tasks, or who have had no formal training.

For example, many of our certificate trainees hold positions for which training used not to be required. And some of our trainees from the graduate program are in positions once held by persons trained for other professions—social work, nursing, or occupational or recreational therapy—although the positions do not require the distinctive skills of these disciplines. Although the appearance of trained child-care workers ought to relieve such people for concentration on their own specialties, the child-care workers have, in a few instances, found themselves regarded as a threat by their co-workers of other professions.

Some initial distrust of a newly developing profession—stemming from a lack of knowledge of what the training for that profession entails—is perhaps inevitable, but this disappears as the child-care workers prove themselves on the job. There is sometimes, of course, another kind of rivalry which arises from a distrustful and inflexible attitude toward all children, still unfortunately found among some persons working in some children's institutions. This will yield only to the forces of education, public pressure, and the efforts of enlightened agency administrators.

As the exponent of a new discipline, the child-care worker inevitably becomes a social change agent in some situations. He may find himself in places where he is faced with alternatives—to adapt, when he must, to standards lower than his own; to teach by example and, when he is empowered to do so, by precept; or to change jobs when he feels his contribution is useless. The role of "change agent" is naturally easier for the graduates of the master's program who find themselves in positions of some authority, but it is by no means confined to them.

¹ Hromadka, Van G.: How child-care workers are trained in Europe. *Children*, November-December 1964.

² National Institute of Mental Health Grant No. 511-MH-7919.

a community
center helps
young people
to meaningful
employment
through

NEW CAREERS as human service aides

BERYCE W. MacLENNAN

● In a day-care center in Washington, D.C., a young man presiding over a low table where six small children are having lunch coaxes a little girl to eat by playing a counting game with her. After lunch, he will help the children settle down for a nap, play games with them, or take them on a short trip. He is a day-care aide. In a nearby elementary school, a young woman reads a story to a small group of pupils while the teacher works with the rest of the class on a special problem. Later, she will sit with individual children, prepare materials under the teacher's supervision, and complete class records. She is a school aide. In another school, a young man helps children plan a baseball game, a visit to the zoo, or a painting session. He is a recreation aide. At the same school, another young woman observes children at play, interviews teachers and pupils, and codes and processes data under the direction of a social scientist. She is a research aide. All four are graduates of a training program which prepares young people from low-income neighborhoods for new careers as human service aides, conducted at the Center for Youth and Community Studies, Howard University, Washington, D.C.¹⁻³ All were school dropouts who could not hold jobs before taking part in the program.

What is the purpose of the new careers program? To answer this question, I must go back almost 3 years to the time when the university, with a Federal grant from the Office of Juvenile Delinquency and Youth Development, established the center. One of the first jobs of the center's staff was to determine what kind of community programs would have the greatest effect on the prevention and control of juvenile delinquency. As we surveyed the needs of the poverty-stricken people in Washington, D.C., we

found that there was a shortage of trained professional workers in all human services and that some professional workers had great difficulty providing young people with opportunities for satisfying lives. Many young people in Washington, we found, lacked basic skills, and many dropped out of high school before finishing. Before the antipoverty program under the Economic Opportunity Act of 1964 was set up, there were few jobs for school dropouts between the ages of 17 and 21. Actually, there are still few jobs which provide for promotion and meaningful careers. Many young people therefore withdrew in despair from trying to succeed in constructive ways and adopt a deviant social system.

One idea we at the youth development center thought promising was to determine whether we could reorganize some of the professional jobs in human service and detach from them duties that might be performed by socially and educationally handicapped young persons after limited and short term training and whether training such young persons for such positions was feasible. We recognized, of course, that jobs are not careers and that if we were to succeed in our endeavor, we must also create opportunities for advancement. Thus, our task was to create jobs for young people, design basic training programs, and provide opportunities for further education and career development.

Our first assumption was that we would have to prove the feasibility of training such young people before permanent jobs could be ensured. Therefore in the spring of 1964, after Washington Action for Youth (WAY), a program to demonstrate delinquency prevention, promised to employ all graduates and to make additional positions available when needed, we launched an experimental program to

train 10 socially disadvantaged young people to work as human service aides in three different fields—child care, recreation, and research into the problems of young people.

We were interested in reaching young people in trouble, young people who could not sustain effort when they met frustration and whose past performance belied their capabilities, young people in whom qualities such as warmth, sensitivity, flexibility, and ingenuity were often masked by defiance and despair. Although we believed we could find boys and girls of high potential among such young people, we did not know how to select them. Therefore, we set only minimal requirements. Applicants had to be between 16 and 21 years of age, from poor families living in high delinquency areas, free of infectious diseases, and not subject to pending court action. Twenty-three from the neighborhood of the university applied, referred by WAY's youth employment service, the U.S. Employment Service for the District of Columbia, and a recreation center run by our agency. The 10 young people selected had dropped out of school and none were employed. Seven had delinquency records, and two of the three girls had borne children out of wedlock.

A three-part model

Because the experience of other training programs had proved that young people tend to drop out of a program unless highly motivated, we adopted a three-part training model which included immediate assignment to supervised work, skill workshops, and a central educational and counseling group, called the core group, in which the young people met every day with their own group counselor.⁴ The trainees were paid \$20 a week. We constantly stressed the opportunity the training offered them to make careers for themselves and to do work which would help others like themselves to a better start in life. We placed them from the start in supervised work for half a day to increase the significance and immediacy of the training. All knowledge imparted and skill taught were geared to the work of human service aides. In the skill workshops, the trainees learned the methods essential to the performance of their jobs; in the core group, they examined their job experience and acquired the background knowledge essential to all human service work.

We used the core group for education and counseling and for the resolution of daily problems.

The core group served as a vehicle for general edu-

cation. In it, we taught the trainees to see how the community works and to identify its resources—sociology; how to understand and observe human behavior—psychology; how to market and manage money—economics. We read newspapers with them—reading improvement; gave them practice in budgeting—arithmetic. Remedial work was also included in the workshop program, and even on the job, for we asked the trainees to write reports, keep regular accounts, and read pamphlets—activities relevant to training but which also gave them practice in basic skills. For instance, one trainee spelled so badly at first he could not use a dictionary. Yet, after he spent 2 weeks transcribing tapes for us and struggling for several hours a day to write what he heard with a tolerance that, I am sure, he would never have been able to show in school, he began to be proficient.

The meetings of the core group performed the central task of counseling the trainees on the meaning of being a human service aide and on how an aide should behave. Here, the young people were encouraged to see themselves in a new light—as respected and potentially successful members of society—and to examine their old values to find which were no longer appropriate. The members of the group put pressure on each other to stick to the job and to complete the training successfully.

The close coordination of the core group discussions and experience on the job made it possible for us to deal with employment problems as they occurred, while they were still small, before supervisors had become annoyed, and while the young people still felt they could succeed. This worked well, though the program was not without its adventures. For instance, one young woman, angry over an incident at work, walked off with a tape recorder. After much discussion, the group spent the weekend persuading her to return the tape recorder and to finish her training.

A graduate of London University where she earned a doctorate in social and clinical psychology, Beryce W. MacLennan has been project director of the Juvenile Delinquency Training Center and associate director of training, Center for Youth and Community Studies, Howard University, Washington, D.C., for the last 3 years. She is also a lecturer in group psychotherapy at the Washington School of Psychiatry and an assistant professor of psychology at the Department of Psychiatry, Georgetown University.



To counteract the possibility of discouragement on the part of these trainees—young people who lacked good work habits and high tolerance to frustration—we used the core group for the resolution of the day-to-day problems of their jobs. The core group leader communicated daily with the job supervisor and immediately took all problems up with the young people. The trainees discussed with the leader such practical topics as the reason why a worker had a supervisor, what happened when a worker was absent from work, and why it was necessary to behave responsibly on the job.

Of the first 10 trainees, 3 were placed in jobs as research aides, 2 as recreation aides, 2 as training aides, 1 as a mental health group leader, 1 as a day-care aide, and 1 as an office worker.

Job development

Since the program began in 1964, we have continued to explore new job possibilities and to refine our training, supported in part by grants from the Office of Juvenile Delinquency and Youth Development and the Office of Education, Department of Health, Education, and Welfare; and the Office of Manpower and Training, Department of Labor. We have trained about 110 aides—18 as preschool and day-care aides;⁵ 14 for positions with the Washington Day Care Association and the model school program of the District of Columbia public schools; 8 as mental health therapeutic recreational aides;⁶ 2 as geriatrics aides; 50 as classroom aides; and 15 as institutional counselor aides. Of the first 38 trained, all but 2 are now employed and only 2 have had trouble with the law. With one or two exceptions, the first 10 aides are not working in their original fields because permanent jobs had not been developed for them. Now our policy is not to start training unless permanent jobs are ready.

Our experience with the first group proved that, although training and education are important, the immediate job itself and the career lines are crucial to success. Because now we do not undertake training unless fully budgeted positions are available, job development has become an important part of our work.

We have concentrated primarily on finding jobs in the public agencies where the need for service is great and the shortage of trained workers acute. To get their help, we first approach agency administrators and discuss with them agency needs, how to develop a service team using an aide, how the team could fit

into their administrative structure, and how the aide positions could be included in the budget. If the administrators are interested, we meet with their key professional workers to consider how the aides can be used and how the duties of an aide can be related to those of the professional and subprofessional workers on the staff. Two major changes can be made: the same service can be performed with a different allocation of tasks; or new services can be added to be carried out either by the aide alone or by the professional worker relieved of routine tasks by the aide.

An aide in a school system could be used this way on a teaching team for 150 pupils in the upper elementary grades. The team would be made up of a master teacher, three teachers, two teaching associates, one classroom assistant, and one aide. The master teacher's job would include administration and supervision of the team.

The class would come together or subdivide, depending on the material to be taught. The teachers and the associates would be responsible for creative work and instruction in small groups. The assistant would help students with paperwork assignments and programmed learning, hear students on work revision, and assist in correcting routine homework. With the help of the aide the assistant would also organize simple games and other enrichment activities; prepare materials; supervise the playground; maintain and operate audiovisual aids; carry out clerical duties such as calling the roll, keeping and transferring records, and ordering and storing supplies; sort materials; tidy the classroom; and work with parent helpers in supervising the lunchroom and the traffic patrol.

All members of the team might go on trips. The master teacher would coach his team members before the trips so that they would have information to give the children as they learn from experience. All members of the team would be available to "listen to" individual children in need of attention.

Relieved of many routine duties by the aides, professional and subprofessional team members could concentrate on teaching.

This is just one example of how a team using an aide could work. Professional workers and administrators would naturally evolve their own staff arrangements in relation to their needs and goals.

Before aides can be taken on by an agency, however, a sequence of positions must be created for promoting competent aides. Once decisions on such issues have been made, job descriptions listing each

member's tasks can be prepared. We then set up a training program, and the agency appoints supervisors who meet regularly with our training staff and evaluators to keep up with the program's progress and to consider changes that may be required. (For instance, in training a group of young people to be classroom aides, we had assumed they had the skills necessary to prepare materials—such as the ability to rule straight lines and to cut paper. When we found they did not, we modified the program to include instruction in these skills.)

Orientation and continuing workshop programs for program supervisors and administrators are an important part of the program. It is a good idea to ask agency staff members to help in training the aides, or learning how to work with them takes time. Administrators must look for the ways in which they can use aides most effectively in their programs, and professional workers must learn how to communicate with the young people—to understand their language and to relate to their values and style.

Administrators and professional workers alike are often distrustful of young people, particularly of those who have not demonstrated reliability, and tend to want older and better qualified helpers. They are often defensive about their own work, resistant to experience that would expose their shortcomings before young people, and consequently, reluctant to treat aides as regular staff members and to permit them to attend their meetings. The objections of these workers must be overcome for we cannot emphasize too strongly that young people must have an opportunity to perform meaningful roles and to earn their living if they are to become responsible adults.

We see training for aides as a new form of vocational education on a work-study model in which basic education and training are combined with and made relevant to a carefully planned and supervised work experience. In this way, we believe that we can combat many of the motivational problems schools find in young people from deprived backgrounds. Although most of the young people enter the aide program with a prejudice against school, we find that after they have been in the program while they develop an interest in education and are willing to take night courses to complete high school. We keep emphasizing the importance of a high school diploma to future education and career advancement, but we point out that the high school graduate still must bridge the great gap between a minimum high school education and college entrance standards. To overcome this difficulty, a community

college could offer an intermediate program to prepare those interested in becoming professional workers and a terminal program to prepare technicians.

Training for technicians

Channels to advancement from aide positions must be created, and training for higher levels of employment must be provided not only for school dropouts, but also for other young people who lack opportunity. Consequently, we are now also training technical assistants. Participants in the program are young men and women between the ages of 21 and 30 from poverty-stricken backgrounds, high school graduates (a few with some college education) who have shown the ability to hold a job and who are interested in working with young people. At present these counseling interns, as we call them, are being trained as core group leaders, employment counselors, or institutional counselors to work in correctional and welfare institutions, Job Corps camps, or in special schools.⁷ This program follows a model similar to the aide training model, although the formal academic component has been increased and the program lasts from 6 to 9 months. This program might fit well into a community college as a single-year diploma sequence in youth counseling.

All counseling interns work under professional supervision. As core group leaders, they conduct group sessions, handle administration, maintain daily liaison with the work supervisors, and help make

Sharing the wonder of growing corn with young boys and girls is one of the rewarding tasks performed by a human service aide at a community day-care center in Washington, D.C.



arrangements for technical instruction. As employment counselors, they interview young people, conduct counseling group sessions, and check and gather information on jobs and young people. As institutional counselors, they act as cottage counselors or as group-life assistants in Job Corps camps.

Values for all youth

Although we have been concerned with training poverty-stricken young people to work in programs which largely serve other young people from similar backgrounds, we believe that this kind of training—training which links well-designed practical experience to basic education and which demonstrates the relevance of formal education to life in the world outside of school or college—could be widely used to stimulate interest in and desire for continued learning and to train all young people to increase their capacity for developing and sustaining satisfactory interpersonal relationships.

In both programs, we believe, there is a core of knowledge and of attitudes which all young people trained as human service workers should be given: an understanding of human behavior, growth, and development; an ability to perceive what is happening between people in their relations with each other and how small groups and institutions work; the cultural ways and expectations of the people with whom they are working; and the resources, structure, and values of their community. We want our trainees to understand that they will have different reactions to different kinds of people, to learn from their mistakes, to take responsibility for their actions, and to tolerate the difficulties and ambiguity of a changing world. Although we still cannot determine initially the potential of a trainee, we try to select young people who are sensitive, concerned about others, realistic, and flexible. Beyond this, we have attempted to devise special training which can be a sound base for further development and which can be readily acquired. For this reason, we are attempting to create a favorable psychological climate for developing in the trainee a basic capacity for moving with relative ease from one kind of human service position to another and thus to be less dependent on the fluctuations of the labor market.

Limited funds led us to set the aide training at 3 months, the counseling intern training at 9. Three months, however, seems too short for a few aides: 9 months too long for many interns. These programs need more flexibility so that individual trainees can

be graduated when they have reached a certain level of performance. For aides, particularly, such training must be viewed only as a beginning, and agencies employing them should devise programs for continuing staff development.

In both programs, we have negotiated for the employment of aides and interns individually with such institutions as the District of Columbia public school system, the District of Columbia Department of Public Welfare, the District of Columbia Recreation Department, and the United Planning Organization, the city's community action agency under the anti-poverty program. This method has resulted in discrepancies in entry levels and salaries. Ultimately it will be necessary to create some uniform standard.

Our project has developed training program which embody the three major objectives of modern rehabilitation: changing the institutional structure to accommodate the worker; creating and using new group supports and pressures which turn the culture of young people toward a positive direction; and working with the individual young person to help him increase his skills and improve his functioning. These training models have meaning not only for the prevention of delinquency and the rehabilitation of delinquent young people, but also for vocational and technical education because they link training with formal education. These new aide roles have significance for the professional worker whose duties in the future will include less direct service and more supervision and program development.

¹ President's Committee on Juvenile Delinquency and Youth Crisis Training for new careers (a community apprentice program developed by the Center for Youth and Community Studies, Howard University, Washington, D.C.). June 1965.

² MacLennan, Beryce W.; Fishman, Jacob; Pearl, Arthur; Klein, William: Training for new careers. *Community Mental Health Journal*. June 1966.

³ Pearl, Arthur; Riessman, Frank: New careers for the poor: nonprofessional revolution in social science. The Free Press, New York, 1965.

⁴ MacLennan, Beryce W.; Klein, William L.: Utilization of group: job training. *International Journal on Group Psychotherapy*, October 1965.

⁵ Bloomberg, Claire M.; Klein, William L.: Day-care aide training curriculum. Curriculum Series No. 4. Center for Youth and Community Studies, Howard University, Washington, D.C. 1965.

⁶ Mitchell, Lonnie E.; MacLennan, Beryce W.; Yates, Edward Justison, Gertrude: A mobile therapeutic community for adolescence. Curriculum Series No. 12. Center for Youth and Community Studies, Howard University, Washington, D.C. 1965. (mimeographed.)

⁷ Klein, William; Walker, Walter: Counseling intern training program. Center for Youth and Community Studies, Howard University, Washington, D.C. 1965.

SOME OBSERVATIONS ON KIBBUTZ CHILDREN

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Although it was once an exotic source of theoretical speculation, the Israel collective settlement or kibbutz has now become almost old hat to American child development specialists. A number of American sociologists and psychologists have visited the kibbutzim, even lived and worked in them, and at the same time have worked through their more naive speculations about what happens to children who from birth are brought up in a thoroughly collectivized system.

This is not to say that we possess definitive research on child-rearing methods in the kibbutzim and their results. We are far from having reached that stage, just as we are a long way from knowing precisely how social class, ethnic differences, and life styles make or different kinds of impact on the personalities of American children. Still, the small but growing body of objective and impressionistic studies of kibbutz children does enable us to conclude that there are few surprises in store about the nature of the kibbutz-bred human being. By American middle-class stand-

ards, he would be considered quite ordinary, normal, and similar to the more carefully nurtured middle-class person in this country.

Two recently published volumes reinforce this impression. The first is by Albert I. Rabin,* a psychologist who has published a number of earlier papers on kibbutz children. In his book, "Growing Up in the Kibbutz," Rabin presents a comprehensive discussion of his data and conclusions. The second is a proceedings volume** based on a one-week institute held in Israel in 1963 at Oranin, the pedagogical center and main teacher-training institution for the kibbutzim.

A comparative study

Rabin gathered his data in 1955¹ and 1962, designing his study as a comparative assessment of kibbutz-reared children and rural non-kibbutz children brought up in a typically structured family in Israel. Adopting a cross-sectional approach, Rabin took four samples from the stages of infancy, pre-adolescence (10-year-olds), adolescence (17- and 18-year-olds), and later adolescence or young adulthood (18 to 21). The total extended sample of kibbutz children was 177, and of non-kibbutz children, 121.

The investigation made use of the Griffiths Mental Development Scale for Infants, the Vineland Social Maturity Scale, a draw-a-person test, the

Rorschach ink blot and Blacky pictures tests, the Thematic Apperception Test (TAT), sentence completion methods, and questionnaires.

Accepting Rabin's data and findings at face value, his research reveals practically no striking or deep personality differences in his samples. Except for a small but convincing cluster of evidence that kibbutz children undergo a developmental lag in infancy, which is quickly offset, the children seem remarkably similar along all basic psychological dimensions.

There are a number of expected, but far from great, variations having to do with family attitudes or feelings, stemming no doubt from the group method of upbringing. For example, Rabin finds minor evidence of less intense sibling rivalry among kibbutz children; greater hostility toward parental figures "at a deeper, unconscious level"; more anxiety; less intensive involvement with families; perhaps more repression of sexuality; less "narcissistic" orientation to "object choices"; less intensity of "Oedipal attachment."

But Rabin often needs to push and prod his data to come up with these vague (and suspiciously contradictory) conclusions, and unless one wants to make mountains out of psychoanalytic molehills, the young adult products of kibbutz and non-kibbutz upbringing appear entirely interchangeable. One suspects that by the time Rabin's subjects attain later adulthood there will

*Rabin, Albert I.: *Growing Up in the Kibbutz*. Springer Publishing Co., New York. 1965. 230 pp. \$5.

**Neubauer, Peter B. (ed.): *Children in Collectives: Child-Rearing Aims and Practices in the Kibbutz*. Charles C Thomas, Springfield, Ill. 1965. 383 pp. \$11.50.

be no measurably significant personality differences between the kibbutz and non-kibbutz samples. (But there may well be significant and persistent differences when it comes to spiritual or ideological values, which happen to be beyond the scope of Rabin's study.)

Pragmatism and idealism

For a broader and more ideological portrayal of child-rearing practices in the kibbutz, we can turn to the Oranim volume. While this transcript of proceedings from the Oranim Institute on Child Development in Kibbutzim leaves something to be desired from the editorial viewpoint, it is a rich and rewarding book. Its chief merit is that it contains full and frank statements by clinical and pedagogical spokesmen of the kibbutz movement. These spokesmen are less prone to sermonizing on arcana of psychological theory than their colleagues from abroad, also represented in this volume.

The kibbutz educators and clinicians reflect an unusually shrewd combination of pragmatism and idealism, and also high dedication to the improvement of their child-rearing system. Repeatedly they point to imperfections in the basic educational structure, and do not hesitate to voice their own frustrations. The earnestness of their search for more effective ways of promoting independence, creativity, and spiritual growth in the second generation cannot be doubted.

Rachel Manor, a psychiatric social worker at the Oranim Child Guidance Clinic, expresses this unflinching frankness on the topic of excessive group sanctions, and also indicates her openness to new thinking about controversial kibbutz issues in these words:

A child in our society should know that he can express, verbally, his discontent and his anger, and that, in so doing, he is not a bad child, a deviant from his group. . . .

Sometimes it would be better that the educator said "No!" and not the group. . . . The group *throttles* them! I remember a meeting of young parents who had themselves been kibbutz children; the expression "We were throttled" was repeated several times. I think we have to take heed of that.

Someone said, during lunch: "Has a child ever said to you, 'Kibbutz life is no good?'" Our children don't say it; they are afraid to say it, because they feel we won't allow them to say it. And I

think we don't permit them to say it because *we* are afraid. (*Interjection:* Perhaps they haven't much reason to say it.) But they *have* to be able to say it sometimes! Only then will they be acting spontaneously; only then, I feel, will they be able to make changes within the older kibbutzim! We say: "You have to make changes, you have to give your opinions on things. . . ." But they don't dare to do it; we say it to them in such a way that they don't dare to do it. . . .

I want to bridge the gap that clearly exists between our personal feelings and attitudes and our declarations. I feel that gap in the adults, and especially in the educators. And we have to work on that question with parents, too. This is a very important aspect of the problem of individualization.**

The theme expressed in the above passage—the tension between the assertion of powerful group controls and the yearning for uninhibited individualism—is often encountered in the Oranim volume, and we must assume that it is a leading preoccupation of kibbutz educators.

Despite their readiness to admit shortcomings, the kibbutz spokesmen are by no means defensive or apologetic about their system. They sound convinced of its superiority to other pedagogical approaches, and they answer fundamental criticisms with gusto and assurance.

The same Rachel Manor who voices almost harsh self-criticism about group sanctions presents a sensitive and highly positive account of socialization in early childhood and latency. She believes that the kibbutz provides an improved emotional climate for the child, freeing him from the often exaggerated and threatening need to win love and affection, so ambivalently offered and withdrawn in many Western nuclear families. Manor stresses that, along with pressures to conform, the group provides a deep and very reliable security and a consequent reduction of guilt feelings.

Parental influence

Although the peer group is a dominant psychological instrumentality in kibbutz living, the parental influence is in many respects just as powerful as it is in non-kibbutz communities. Mordchai Kaffmann, a child psychiatrist on the staff of the Oranim Child Guidance Clinic, believes that emotional disturbances of childhood depend pri-

marily on the family constellation. According to Kaffmann, the usual range of child-parent relationships can be found in the kibbutz, including overpermissiveness, overprotection, rejection, and so forth.

For the time being, the rather scanty clinical evidence suggests that there is neither a greater nor lesser incidence of psychopathology among kibbutz children as compared with non-kibbutz controls, although deeper kinds of problems are definitely less frequent among kibbutz children. (For example, homo sexuality and hard-core delinquency are practically unknown.)

In a chapter in the Oranim volume on family life and the role of women the discussion lends support to the speculations of sociologists and other observers of kibbutz evolution (among them, Talmor-Garber²) concerning the appearance of a strong "familistic trend" in the kibbutzim. Just as the strict and somewhat ascetic standard of a bygone era are becoming mellowed, so the distrust of the nuclear family as a conservative force and a center for the "private-consumption" approach to life now seems to be abating. But this change is being strongly resisted by the more ideologically committed leader who feel that a "familistic trend" carried too far would undermine the chief values of the kibbutz society.

Why the similarities?

The Rabin and Oranim volumes both make it clear that kibbutz education for the most part functions effectively, and that the kibbutz-reared child achieves a satisfactory adjustment as a second generation member of the kibbutz. Despite considerable differences in the fundamental approach to child-rearing, the kibbutz product is strikingly similar to the non-kibbutz product, not much better and no worse.

What are we to make of this state of affairs? Is child-rearing method a matter of indifference? It is hard to abate our belief in the importance of early socialization experiences and the role of the nurturing adult in the early years of life. As the 18th-century German poet Jean Paul Richter put it: ". . . if we regard all life as an educational institution, a circumnavigator of the world is less influenced by all the nations that he has seen than by his nurse."

Richter is not the only one we could note. A long line of natural philosophers and humanist poets have with confidence made the claim which begins "... if you will but give me the child until his seventh year" But in point of fact, the number is legion of those who have indeed been given the child for what purportedly amounts to complete control over infancy and early childhood, with the common result of extraordinary variance between what the adult upbringer intends and what the child actually becomes as an adult.

The explanation may inhere in the simple fact that no single adult can be "given" complete control of the child or bring him up as a socialized human being. With the exception of those rare and for the most part monstrous examples of children reared in complete isolation (for example, the child kept locked up in the attic by an insane grandmother), the world thrusts between the caretaker and the child an endless bombardment of influences which serve to mitigate the effects of even the most painstaking and elaborate of child-rearing regimens.

It is not different with respect to the kibbutz child and the collective system

of upbringing. The booming, buzzing, non-kibbutz world intrudes. In actuality, the kibbutz is a cosmopolitan hamlet in the midst of a percolating Israel culture, and the child grows up to become not a citizen of his settlement, but of a larger Israel community.

Who is to say to what extent psychology has been contaminated by sociology, or in what ways the unique elements in the collective system are re-incarnated in the developing child so as to assimilate him to the general Israel culture and not to a particularized kibbutz subculture? In any event, evidence suggests that most kibbutz-bred persons who leave for the city (or even abroad) make an acceptable adjustment to a non-kibbutz environment.

A reassuring conclusion

Should we be saddened or reassured to learn that the kibbutz produces no new personality, that radically different child-rearing methods do not necessarily yield basically different human outcomes?

By all means, we should be reassured. For, on the basis of the kibbutz experience, the conclusion seems to be that if

a child is brought up in a humane and stable environment infused with love, tenderness, respect for work, and enlightened moral standards, then the basic product will be unspectacular but sound, irrespective of even major differences in child-rearing method.

Kibbutz-bred persons are by no means supermen—but since the world is not yet ready for supermen, we should probably be content with what we have and even be grateful that a benign fate prevents us from breeding a higher race of men who would surely be out of place in our present world. No doubt when the world is ready for supermen, they will appear; and it is heartening to surmise that they will appear with single or multiple mothering, in collective children's homes or private apartments, with intense and less than intense "Oedipal attachments," speaking Hebrew or English or Chinese.

¹ Rabin, Albert I.: Kibbutz children—research findings to date. *Children*, September-October 1958.

² Talmon-Garber, Y.: Social change and family structure. *International Social Science Journal*, Vol. 14, No. 3, 1962.

guides and reports

ACCOUNTING AND FINANCIAL REPORTING. Child Welfare League of America, Inc., 44 East 23rd Street, New York, N.Y., 10010. 1966. 40 pp. \$1.

Contains four papers on the applications of cost analysis and uniform accounting methods to children's institutions and other social services.

A GUIDE TO MEDICAL CARE ADMINISTRATION. Volume 1: Concepts and principles. The Program Area Committee on Medical Care Administration, American Public Health Association, 1790 Broadway, New York, 10019. 1965. 106 pp. \$2.

Part I of this first volume of a two-volume guide discusses the elements of

good medical care—defined as accessibility, continuity, quality, and efficiency. Part II discusses principles of medical care administration in the dimensions of program planning, management, and evaluation. A glossary of terms and a historical chronology are included.

PATIENT STUDIES IN MATERNAL AND CHILD NURSING: a family-centered student guide. Ann L. Clark, Hella M. Hakerem, Stephanie C. Basara, and Diane A. Walano. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 19105. 1966. 305 pp. \$6.75, clothbound; \$4.75, paperback.

A casebook for student nurses with questions focused on sharpening the student's observation of intrafamily rela-

tions and the emotional experiences of parents and children in specific nursing situations.

CHILD ABUSE LEGISLATION: Analysis of reporting laws in the United States, Part 1. Children's Division, The American Humane Association, Post Office Box 1266, Denver, Colo., 80201. 1966. 36 pp. 35 cents.

Tests 47 State laws dealing with the reporting of child abuse as they existed in 1965, against 10 criteria of adequacy.

EFFECTIVE COMMUNICATION WITH ADOLESCENTS IN INSTITUTIONS. Gisela Konopka. Child Welfare League of America, 44 East 23rd Street, New York, 10010. 1965. 19 pp. 25 cents.

Discusses the obstacles to communication between teenagers in institutions and their adult caretakers.

BOOK NOTES

CHILDREN IN THE HOSPITAL.

Thesi Bergmann in collaboration with Anna Freud. International Universities Press, New York. 1966. 162 pp. \$3.

The child as a hospital patient differs greatly from the adult patient, according to the authors of this analysis of the reactions of children to chronic illness and hospitalization. Because the child cannot distinguish between serious and slight illness, or major and minor surgery, they maintain, his fears and fantasies are equally strong in all stays in a hospital and any stay is "painfully long."

The authors' observations are made chiefly in relation to children who were at some time during the last 20 years patients in Rainbow Hospital, a hospital for children with chronic disease, operated by the medical school of Western Reserve University. The authors describe the meaning to the children of long illness, pain, discomfort and deprivation, separation from home, surgery, and treatment. In each case the reaction of the children is interpreted on the basis of the psychoanalytic theory of child development.

The authors see a need for an organized method of "mental first aid" in the hospital for the child patient. They recommend that such a method be flexible, and that it involve the parents of the child as well as the medical and nursing staffs. "The majority of child patients . . . whether acutely or chronically ill, will benefit greatly from any plan under which the needs of their minds are considered to be as important as the needs of their bodies," they conclude.

THE SUCCESSFUL STEPPARENT.

Helen Thomson. Harper & Row, New York. 1966. 229 pp. \$1.50.

It is not producing a child that makes a good parent, but love, patience, and understanding, maintains the author of

this book about the problems of stepparents and stepchildren. For this reason, she says, the relationship between a child and a stepparent may be as beneficial as that between a child and his natural parent.

With this in mind, she discusses, with case illustrations, many of the problems faced by stepfamilies as families and their members as individuals. These problems include the first meeting between a child and a future stepparent (the importance of which, she thinks, cannot be overemphasized); who shall administer discipline; how to handle the problem child or one who is hard to love, withdrawn, or possessive; adoption of stepchildren; custody action; and the working stepmother.

The author advises stepparents not to see themselves as being in competition with the parents they are replacing. The wise stepmother, she says, will not be overanxious to do a good job; the wise stepfather will recognize his limitations within what may be an undefined relationship with his stepchildren.

A custody action, she points out, regardless of the results, can upset both parents and children. Often it is the stepparent's understanding alone that makes it possible for a father or mother to absorb the shock of the experience and for a child to escape consequences that could scar him emotionally for life.

IN-SERVICE CASEWORK TRAINING.

Elizabeth Nicholds. Columbia University Press, New York. 1966. 308 pp. \$6.

Written by the chief of staff development of the Connecticut State Welfare Department, principally for use in in-service casework training for new workers in public welfare agencies, this book, the author suggests, may also be helpful to experienced caseworkers and supervisors of new workers.

The author concentrates on begin-

ning workers, because, she says, she has found that the yearly loss of workers in public welfare agencies is highest among beginners. She maintains that many beginners leave social work because they soon become discouraged by their inability to meet their client's needs. In her opinion, early discouragement could be countered by supervisors who help "fledglings" gain useful experience, improve working methods, learn how to work with every type of client, understand human motivation and, at the same time, know their own limitations.

In addition to describing such processes as intake, case recording, interviewing, and measuring case movement the author presents material on the growth and development of children and discusses such problems as working with unwed mothers and neglecting parents, removing a child from his home, the use and misuse of authority, and family evaluation and counseling.

The book includes a chapter on counseling the family of a mentally retarded person, written by Rose Savoca, assistant director for mentally retarded children of the County of Cuyahoga Welfare Department, Cleveland, Ohio.

SEX AND THE COLLEGE STUDENT.

Committee on the College Student Group for the Advancement of Psychiatry. Athenaeum, New York. 1966. 178 pp. \$4.50, clothbound; \$2.45, paperback.

College administrators should make explicit their attitudes toward sex on the campus, and these attitudes should be reflected in policies that are consistent in principle and flexible in individual cases, according to recommendations in this report of a study by the Committee on the College Student of the Group for the Advancement of Psychiatry.

The report focuses on issues, policies, and practices relating to the sexual behavior of college students. Composed of nine psychiatrists and three consultants from college campuses—a dean, a faculty member, and a clinical psychologist—the committee interviewed deans and counselors of selected campuses, reviewed material submitted by 37 institutions, surveyed relevant literature, and examined case histories drawn from their own clinics and research experience.

Finding sex both more freely discussed and engaged in on campuses today than a generation ago, the committee's report discusses the relationship of sexual behavior to individual development, the dynamics of sexual behavior among college students, and the failure of both *laissez-faire* and inflexible repressive college policies to deal with the issue realistically. It recommends that courses in sex education encourage frank discussion between students and adults.

In their efforts to cope with sexual lives, college students are troubled by the failure of adults to provide them with clear-cut standards of behavior, according to the report. The college must act for parents, but it can be helpful without running into conflict with the student's right to privacy, it maintains.

CAREERS IN SOCIAL WORK. Frances A. Koestler. Henry Z. Walick, Inc., New York. 1965. 126 pp. \$3.75.

The field of social work, the author of this "comprehensive survey" of social work as a career says, has "horizons unlimited." She backs up her thesis by pointing out that many positions are open in every region of the country needs child workers, the end of the need for them is not in sight, working conditions are good, and, in social work, the worker can grow as a person and in his profession.

The book was prepared principally for guidance workers in college and high schools and the students they serve.

Appendices list graduate schools of social work, social work career centers offering summer jobs, and publications on social work as a profession.

DETERMINANTS OF INFANT BEHAVIOR III: proceedings of the Third Tavistock Study Group on Mother-Infant Interaction, held at the House of the Ciba Foundation, London, September 1963. Edited by B. M. Foss. Foreword by John Bowlby. John Wiley & Sons, Inc., New York. 1966. 264 pp. \$8.

The 14 contributors to this report on the third of a series of seminars on relations between mothers and infants conducted by the Tavistock Institute of Human Relations in England include

psychologists, psychoanalysts, and zoologists from several countries. They report research on animal (rats, monkeys, and baboons) and human infants and mothers.

The seven papers on human infants and mothers include studies of infants in unfamiliar situations, infants with withdrawn mothers, how infants are carried by adults, and differences in behavior between the "only" and the "youngest" child in four different environments in Israel. In addition to reporting on the results of research, the four papers on animals discuss the possible bearing of the findings on human behavior.

PSYCHOPATHOLOGY OF CHILDHOOD. Jane W. Kessler. Prentice-Hall, Englewood Cliffs, N.J. 1966. 533 pp. \$8.25.

A general survey of the clinical, research, and theoretical aspects of the diagnosis and treatment of psychopathology in children, this book discusses, among other subjects, anxiety, aggression, and guilt in disturbed children; problems in developing speech and language; learning disorders; psychoneurosis in children; psychosis in early childhood; juvenile delinquency; psychotherapy; work with parents; and treatment at home.

The author, a professor of psychology at Western Reserve University, maintains that the children most likely to develop emotional disturbance are those in "unfavorable circumstances," among whom she includes abused children, children in foster homes, and the children of chronically ill, mentally ill, or alcoholic parents. She suggests that much could be done to prevent pathology among children by mass social programs conducted through medical and mental health clinics, hospitals, child placement agencies, juvenile courts, public and private welfare agencies, and schools.

STAFF DEVELOPMENT IN PUBLIC WELFARE AGENCIES. Carol H. Meyer. Columbia University Press, New York. 1966. 230 pp. \$6.

The content, method, and purpose of a public welfare agency's inservice training program for workers who have not had professional social work training should be shaped by the needs of the agency, according to the author of

this book, an associate professor at the Columbia University School of Social Work.

Such a training program, the author maintains, should not be theoretical, but its content might be confined to, "... description of client behavior, significant psychosocial symptomatology, expected responses, and typical situations. . . . The worker," she suggests, "may be trained to see and to hear, to exercise judgment about what seems relevant and significant, and to make some decisions based upon his findings. . . . think about what he is doing, to be accepting of his clients and to be helpful, but always within the limited content of prediagnosis and generalization."

The author also discusses the stresses and strains within welfare departments, ways in which professional and non-professional staff members can work together, ways of training new staff members, and ways of keeping supervisors and experienced staff members abreast of the principles of social work.

INTELLIGENCE AND AFFECTIVITY IN EARLY CHILDHOOD: an experimental study of Jean Piaget's object concept and object relations. Thérèse Gouin Décarie. Foreword by Jean Piaget. Translated by Elisabeth Passtor Brandt and Lewis Wolfgang Brandt. International Universities Press, New York. 1966. 230 pp. \$5.

The purpose of the study on which this book reports was to find "testable hypotheses" of intellectual growth from the theories of Jean Piaget and the Freudian ego psychologists through observation of 90 children, aged 3 to 20 months. A lecturer in psychology at the University of Montreal and at McGill University, the author discusses her essentially psychoanalytic method of reaching an understanding of the ways in which the child develops "object relations"—relationships to people and things outside himself—in connection with Piaget's theories of intellectual growth.

She concludes "that any study of affective phenomena must take cognitive processes into account, and that any study of intellectual phenomena must not disregard affective modalities. All evidence," she maintains, "points to the inseparability of these two aspects of personality. . . ."

BASIC SOCIAL GUARANTEES THROUGH PUBLIC WELFARE

proposed by the Advisory Council on Public Welfare

Federal guarantees of adequate public assistance and comprehensive social services as rights for all who need them were recommended by a 12-member Advisory Council on Public Welfare in a report submitted to Secretary of Health, Education, and Welfare John W. Gardner on June 29, 1966. Appointed in July 1964 at congressional direction by the then Secretary of Health, Education, and Welfare Anthony J. Celebrezze, the Advisory Council, now disbanded, was charged with reviewing "the administration of the public assistance and child welfare services programs for which the Social Security Act authorizes Federal funds." In addition to 18 all-day meetings in Washington, D.C., it held open hearings in 6 cities in the various regions of the country during which it received testimony from 350 persons about the needs of people in these localities. The Council's 148-page report, now available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402 (price \$1), includes the following condensation of its proposed "new nationwide program of basic social guarantees":

1. General Proposal

The new program would require that adequate financial aid and social services be available to all who need them as a matter of right. To make this possible a new pattern of Federal-State cooperation is proposed. The Federal Government would set nationwide standards, adjusted by objective criteria to varying costs and conditions among the States, and assume the total cost of their implementation above a stipulated State share. The States would thus be freed to concentrate their efforts on meeting human needs, relieved of the present multiple Federal program requirements and the constant pressure to find new sources of State financing. The required components for participa-

tion in this new program are described below.

2. Assistance Standards

A floor of required individual or family income would be established for each State in terms of the cost of a modest but adequate family budget for families of various sizes and circumstances as established by objective methods of budget costing. This could constitute the minimum level of assistance which must prevail in that State.

3. Eligibility for Aid

All persons with available income falling below this established budget level would be entitled to receive aid to the extent of that deficiency. Need would be the sole measure of entitlement and

irrelevant exclusions such as the based on age, family composition or situation, degree of disability, presumption of income not actually available to the applicant, low earning capacity, filial responsibility, or alleged employability would not conform with requirements of this program. Provision for immediate emergency aid when needed would be required.

4. Eligibility Determination

Applicants for aid would establish their initial eligibility by personal statements or simple inquiry relating to the financial situation and family composition, subject only to subsequent same review conducted in such manner as to protect their dignity, privacy, and constitutional rights.

5. Child and Youth Welfare Services

The Federal Government would specify the required components of child and youth welfare services to be included within the comprehensive program. These would include protective and social services for children in a vulnerable situation, foster care placement in homes and institutions, reasonable rates of reimbursement for adoptive placement services, services for unmarried mothers, homemaker services, day care, other types of group service, provisions for specialized institutional care, probation and social service (where not otherwise available), special programs for young people, and services related to the licensing of nongovernmental programs. Special provisions would be required

young people coming to the attention of authorities for unlawful or antisocial acts or believed to be vulnerable to such activity.

It is the goal of the Council that adequate child welfare services should be available to all children in need of them as a matter of enforceable legal right. Recognizing, however, the practical difficulty of assuring the universal availability of a full range of services immediately, it is recommended that the Federal Government distinguish between services which must be available to all eligible children and those which may be included in the comprehensive program on a progressively expanding basis within the same financing pattern.

Other Social Services

The comprehensive State plan would also include other specified social services for families, older persons, individuals with special problems relating to health or other handicaps, and for a better ordering of community social resources. Again a distinction would be made between those to which individuals would be entitled by legal right on the basis of universal availability and those approved for inclusion within the State plan on a basis of progressive coverage. Examples of such social services would include the following: neighborhood advice and referral centers; services to assist the aged and homebound in meeting their medical, housing, recreational, social and activity needs; supportive services for mothers with special problems; social services related to health needs including family planning; services to advance employability—including aid in moving to new locations promising employment opportunity; and community planning services.

Legal Rights

Entitlement to all benefits and services within this program would be protected by the following legally enforceable rights: (1) the right to apply and receive prompt, objective, and impartial determination of eligibility for and provision of benefit or service, (2) the right to be given a fair hearing against unacceptable judgments, by an impartial appeals agent, (3) the right to representation in appeals, by an attorney whose services and costs would be compensated by the agency if not otherwise provided for, (4) the right to court

review, and (5) the obligation on the agency to publicize the conditions of entitlement to all benefits and services. The right to services would be conditioned on the need for service rather than income level.

8. Personnel

Because the fulfillment of all these objectives depends upon a dramatic increase in the present limited national pool of professional social workers, social work aides, and related auxiliary personnel, special legislation for Federal financial aid to encourage and expand the training of such workers is essential to this plan.

9. States' Share

The State's share in the financing of this comprehensive program would be established each year on a total dollar basis determined by objective criteria related to its fiscal capacity and effort.

10. Federal Share

For States operating under this program of basic social guarantees, the Federal Government would assume the full financial responsibility for the differences in cost between the State's share and the total cost of the new program. This constitutes in effect a revolutionary reversal of roles of the Federal and State governments in the financing pattern. Under the present system it is assumed that the primary responsibility for determining the scope, level of benefits, and financing of the

various components of a public welfare program rests with the States. Under the new proposal national standards of performance would be recognized as calling for an equivalent national assumption of financial responsibility by the Federal Government. Within this pattern, since no differentials would be applied among types of expenditures, Federal auditing would be limited to actual expenditures and program performance in terms of required Federal standards. States would, of course, be required either to finance their share by State funds or to make comparable financial arrangements with their political subdivisions to assure equitable and universal standards throughout the State.

11. Interim Option

States not yet prepared to participate in the new nationwide program could continue on a transitional but limited interim basis to operate under the existing titles. States' rights and State options would thus be protected during the period of accommodation but the fiscal, policy, and administrative advantages to the States of a plan which fixes and limits their total financial obligation in relationship to their fiscal capacity would be a powerful incentive to cooperate in this new plan of partnership. The simplification of accounting, reporting, and audit procedure alone would eliminate many of the complexities and confusions that presently plague Federal-State relationships.

Advisory Council on Public Welfare

Fedele F. Fauri, *chairman*, Dean, School of Social Work, University of Michigan.

Mrs. DeLeslie Allen, *Vice-Chairman*, Department of Social Welfare, National Council of Churches.

Walter E. Brown, M.D., *Glass-Nelson Clinic*, Tulsa, Okla.

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Mrs. Cernoria D. Johnson, *Director*, Washington Bureau, National Urban League, Inc.

Guy R. Justis, *Director*, American Public Welfare Association.

Leonard Lesser, *Assistant to the President*, Industrial Union Department, AFL-CIO, Washington, D.C.

C. Virgil Martin, *President*, Carson Pirie Scott & Co., Chicago, Ill.

Frank W. Newgent, *Director*, Division for Children and Youth, Wisconsin State Department of Public Welfare.

Engene Nickerson, *County Executive* for Nassau County, New York.

Sanford Solender, *Executive Vice-President*, National Jewish Welfare Board.

Elizabeth Wickenden, *Social Welfare Consultant*, New York.

HERE and THERE



White House Conference on civil rights

"... it has been held in some quarters that conferences such as this are but 'talk.' The answer is that in an honest and accurate sense, they *are* talk. But so, too, was the Sermon on the Mount . . ." Thus, Roy Wilkins, director of the National Association for the Advancement of Colored People, answered the stock criticism of all conferences, including the White House Conference To Fulfill These Rights, held in Washington, D.C., on June 1-2, 1966, where he gave the closing address.

This was a conference frankly dedicated to talk, most of it spontaneous discussion among participants. The few platform speakers included the President of the United States, Lyndon B. Johnson; the Vice-President, Hubert H. Humphrey; the Solicitor General, Thurgood Marshall; and A. Philip Randolph, president of the Brotherhood of Sleeping Car Porters, whom many consider the "grand old man" of the civil rights movement. But during most of the time, the 2,600 participants were divided into 12 committees for informal discussion. Unlike the earlier "Planning Conference," this one offered identical agenda for each committee, with each discussing—under the leadership of rotating panels of experts—the same topics: economic security and welfare, education, housing, and administration of justice.

Participants included people widely known in business, national organizations, academic circles, or government, and people known only in one small neighborhood; many of the prosperous and some of the poor (200, it was said)—but nearly all articulate. They told what had been done about specific problems in specific places, what had

not been done, and what they believed should be done.

Much of what they said documented vividly some well-known but often repressed facts about discrimination, persecution, failure to provide due protections and supports. There were also some success stories and a few proposed innovations: a flourishing basic education program in which adults were paid a small sum of money to give their time and effort to learning basic skills; the proposal for a nonprofit "self-help" cooperative financed by the Negro community, in which all would contribute according to their means toward massive programs of literacy, job training, and housing; the suggestion that transportation by monorail be used to bring children and adults from the inner city to educational parks on its periphery, providing education from preschool through junior college and offering all possible services and facilities.

For those whose primary work is with or for children, the sessions offered a mixture of horror and hope: horror at reminders of what has been inflicted on our children, hope spurred by evidence of fortitude and determination. A clergyman from Sparta, Ga., bore witness to the anguish of a parent whose son was the only Negro in a white high school. "Even Shakespeare," he said, "could not reveal the agony and heartache" of such a parent. Each evening when he faced his wife, he said, he was "afraid to look at her" for fear of what her face might reveal about the boy's experience during the day. Three times his son suffered physical assault, and when the father suggested to a school official that children should be protected, he was asked, "What do you expect me to do? Hold him in my lap?" Yet the boy and his parents survived the ordeal, their en-

durance strengthened by the conviction that it would redound to the benefit of other children.

Although the original Conference plan precluded recommendations, the participants insisted on preparing some and bringing them to a vote. The result will be included in a report of the full proceedings being prepared for the consideration of responsible officials. Also available for policy consideration is a 104-page report issued before the Conference by the 30-member council appointed by the President, a report useful to a large extent as the basis of Conference discussions. Some conferees were surprised by its forthright recommendation that "there should be explicit acceptance of the government's responsibility for guaranteeing a minimum income to all Americans." The acceptance of government responsibility in the four major areas of discussion and determination that it be exercised were, in fact, the keynotes of the Conference, sounded alike by government officials and nongovernment participants.

At the final dinner meeting, a civil rights leader was asked what he thought such a conference accomplishes and whether it was worthwhile. "We can go back," he answered, "and to them, 'You were discussed. They care they are trying.' That makes worthwhile."

—Elizabeth Herzog

For migrant children

The education departments of 16 States—Arizona, California, Delaware, Florida, Oregon, and Washington—are participating in a 3-year project to improve educational opportunities for children of migrant farm workers through a grant of \$109,900 from the U.S. Office of Education under the Elementary and Secondary Education Act of 1965. The project will be directed by a steering committee of the State chief school officers or their representatives, under the administration of California. Each State will have its own project staff.

The project has these goals:

- To develop methods of identifying the educational needs of migrant children, of keeping track of the children's movements, of transferring pupil records from school to school, and of

planning coordinated educational programs for children as they move from State to State.

- To develop educational materials and guidelines for teaching migrant children, and to provide supplemental inservice training for teachers to help them understand the problems of migrant children.

- To help selected schools develop model educational programs for migrant children.

Neighborhood centers

Do U.S. citizens need local advisory services similar to those provided by the Citizens' Advice Bureau (CAB) operated by the British Government, to answer peoples' questions on education, employer and employee relationships, insurance, personal finance, health services, and the like? This question was central to an inquiry recently completed by the Columbia University School of Social Work under the direction of Professor Alfred J. Kahn.

The study focused its attention on information and referral services offered by voluntary and public agencies in New York City, but also included brief reviews of services offered in other cities. In no place did the study find comprehensive advisory services.

Finding that most Americans are served by networks of increasingly complex systems of service, entitlement, and help, the inquiry indicated that they could and would use centers for information and advice. Such centers, however, the study group suggests, should be shaped to meet the needs of this country and should not be copies of those operated by CAB. It recommends that local "Neighborhood Information Centers" (NIC) be set up to give information and advice on simple and complex matters relating to law and rights and how the citizen may proceed to obtain his rights; to offer referral service and counseling; to follow through with clients until their rights are recognized; and to work for policy and program changes as necessary.

The report suggests:

The first centers should follow several organizational patterns; some should be under public control, others under voluntary; in other words, the first centers should be experimental to determine the most effective systems and methods. The sponsors could include

community action programs, public welfare systems, the social security system, existing public and private agencies, and a voluntary network. Centers should be flexible and impartial, have an "open door" atmosphere, and offer a wide range of expert services. Workers should be paid, and both professional and nonprofessional workers should be employed, though most should be professional.

A report of the study, "Neighborhood Information Centers: A Study and Some Proposals," is available from Columbia University School of Social Work, 2 East 91st Street, New York, N.Y., 10028. (Price: \$1.)

Early childhood education

Project Head Start's summer programs for 1965 apparently had little effect on the size of nursery school and kindergarten enrollment in the fall of 1965, according to a recent report of the Office of Education on a survey of 3-, 4-, and 5-year-old children in the United States enrolled in nursery schools and kindergartens, both public and private. At that time, the enrollment was 3,407,000, or 27.1 percent, of the children of these ages; in October 1964, it was 3,187,000, or 25.5 percent. These estimates are based on data from the October 1965 Current Population Survey of the Bureau of the Census obtained from 35,000 sample households in the 50 States and the District of Columbia.

Enrollment in fall 1965 for each age was as follows: age 3—203,000, or 4.9 percent, mostly in private nursery schools; age 4—683,000, or 16.1 percent, 59 percent of whom were in kindergartens (mostly public) and 41 percent in nursery schools (mostly private); age 5—2,521,000, or 60.6 percent, 98.2 percent in kindergartens (mostly public) and 1.8 percent in nursery schools (mostly private). In addition, 443,000 5-year-old children were enrolled in regular elementary school classes above the kindergarten level.

Family income seemed to have a bearing, according to the report. The higher the family income, the higher the percent of children in nursery school or kindergarten. Region made a difference, too: the West had the most 3-year-old children enrolled; the Northeast, the most 4-year-olds. The South had the least at all three ages, though it was the only region to have more nonwhite

than white 3-year-old children in school.

Copies of the report, "Nursery-Kindergarten Enrollment of Children Under Six: October 1965," can be obtained for 20 cents from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

* * *

Because they are now 5 years old, special arrangements have been made for the children who have taken part in a 2-year preschool enrichment project conducted by Howard University in Washington, D.C., under a grant from the Children's Bureau, to continue as a group in a special kindergarten class within the public school system of the District of Columbia, in the school year 1966-67. The children will also be given free transportation and lunches. This will be the first such project to keep the same children together for 3 years.

Preliminary tests show greater gains in IQ scores by the 38 children who attended the project's nursery school than by another group of 65 children who did not participate in the program, used as controls. The Bureau's research division, which has been carrying on the research aspects of the project, points out that the gains are not spectacular and that the additional year together in a special class may help them retain the benefits of the preschool program. If the kindergarten program proves successful, the program may be continued through the second and third grades.

The Social Research Project at George Washington University, headed by Ira Cisin, will carry on the research part of the kindergarten and school program, under a grant from the Children's Bureau.

A full report on the preschool project is in preparation.

Preventive medicine

The first effective vaccine against rubella (German measles), developed by the Division of Biological Standards, National Institutes of Health, Public Health Service, is now available to scientists outside the Institutes, including those employed by pharmaceutical houses, for further testing. NIH announced the development of the vaccine late in April at the meeting of the American Pediatric Society.

The vaccine was tested with the help of the Department of Pediatrics of the

University of Arkansas Medical School and the Arkansas Children's Colony, a State institution for mentally retarded children. Sixty-four children, known to be rubella-susceptible from pretests, who lived together in four cottages, took part, with their parents' consent; 34 were given the vaccine, 30 were not. As a result, the vaccinated children developed immunity without developing fever or rash, and even more important to the experiment, none of their contacts were infected.

A 5-year study to determine the merit of continuous penicillin prophylaxis in preventing the recurrence of rheumatic fever in children and young people was recently launched in India with the support of the U.S. Public Health Service. About 1,000 children and young people, ages 3 to 20, will take part, all of them patients of the Lady Hardinge Hospital and Cardiac Clinic in New Delhi.

None of the participants have had previous penicillin prophylaxis treatment. Half will receive the special treatment at the clinic once a month over the 5 years; the other half, serving as controls, will have an identical number of clinical examinations but will not be given penicillin.

The project is being financed with a grant of about \$92,000 in U.S. counter-part funds under Public Law 83-480.

Handicapped children

Orthopedically handicapped children can benefit from taking part with normal children in recreational group activities at a community center, according to the recently completed evaluation of a 3-year demonstration project conducted in New York City by the Associated YM-YWHAs of Greater New York. The study was supported by a child welfare demonstration grant from the Children's Bureau.

Initiated in May 1962, the project was carried out at the Moshulu-Montefiore Community Center of New York City, under the direction of the agency's director of research, Douglas Holmes. Altogether 47 physically handicapped children, selected through the public schools, hospitals, and other referral sources, participated with normal children in the center's regular group and club activities. Only children who

were ambulatory either with or without prosthetic devices were considered. The project included medical examinations for the children and a casework counseling service for their parents.

According to the judgment of four trained observers, the children as a whole showed improvement in both self-esteem and social skill during their period of participation, but there were wide individual differences. The parents also, for the most part, regarded the program as beneficial to their children. Although 23 children left the program—some for other group affiliations—the parents of 15 of the drop-outs reported they would like to return their children to the center.

As a result of the demonstration, 10 member community centers of the New York City YM-YWHAs now include services for about 100 orthopedically handicapped children in their regular recreation groups.

Mental retardation

Thirty-seven experts in the study of phenylketonuria and other inborn errors of metabolism which may cause mental retardation, or in programs to detect these disorders, attended an International Conference on Inborn Errors of Metabolism, held in Dubrovnik, Yugoslavia, May 30-June 3, 1966, sponsored by the Children's Bureau, U.S. Department of Health, Education, and Welfare, and the Federal Institute of Public Health of Yugoslavia. They came from Belgium, Germany, Greece, India, Ireland, Israel, Mexico, Pakistan, Poland, Scotland, Sweden, Yugoslavia, and the United States. The co-chairmen were Vukan Ćupić, M.D., director of the Mother and Child Health Institute of the Republic of Serbia, Yugoslavia, and Mitchell I. Rubin, M.D., chairman of the Department of Pediatrics, University of Buffalo Medical School (New York), United States of America.

The Conference was the first which the Children's Bureau has organized and supported using U.S.-owned foreign currency under its interchange-of-experts program.

Papers were presented by Drs. George Jervis on "Clinical Aspects of Phenylketonuria and Allied Conditions," Robert Guthrie on "Laboratory Screening and Diagnosis," John Menkes on "Proposed Classification for the Hyperphenylalaninurias," Donogh O'Brien on "Screen-

ing Tests for Other Congenital Abnormalities," Benjamin D. White on "Phenylketonuria—A Public Health Responsibility in Maryland," and Werner Grüter on "Dietary Management."

The participants reported on their countries' efforts to detect inborn errors of metabolism and to develop treatment and management programs. The discussion was open and informal. Many new ideas were aired; new techniques of exploring problems of inborn errors of metabolism were considered; and gaps in knowledge were noted.

The Conference participants set a number of goals for themselves, including efforts to determine how many untreated children with phenylketonuria grow up "normally," and under what conditions dietary management is essential, for how long, and with what result. The Children's Bureau was asked to assist in compiling some of these data.

The proceedings of the Conference will be published by the Children's Bureau. As requested by the participants, the publication will include a listing of technical laboratory centers which are willing to perform special tests for inborn errors of metabolism and on whose staffs there are experts willing to interpret laboratory data and give advice about further study and possibly patient management.

Adoptions

The National Adoption Resource Exchange established by the Child Welfare League of America will begin operation this fall as a nationwide adoption resource to help balance the uneven availability of homeless children and suitable adoptive families. According to the League, the exchange will help adoption agencies find homes for children legally free for adoption for whom there are apparently no adoptive homes in their own areas, by putting them in touch with agencies in other areas where there are prospective adoptive parents.

The exchange will work through 2 State adoption exchanges which the League has helped establish in the last 15 years, will attempt to increase the number of State exchanges, and will work with agencies to help eliminate State laws which now impede interstate adoption. Both public and private agencies in Canada and the United States will take part.

One of the major objectives of the

exchange will be to find homes for children of minority groups or of mixed racial backgrounds by getting around local prejudices. In the Southwest, for instance, children of French-Canadian extraction are acceptable, but those of Spanish extraction are not; the opposite is true in New England. The exchange will try, therefore, to place Spanish-American children in New England and French-Canadian children in the Southwest. It will also help adoptive parents of mixed racial backgrounds find children of similar backgrounds.

The work of the exchange will approximate that of a national adoption exchange operated for the last 7 years by the League and the Bureau of Indian Affairs, U.S. Department of the Interior, through which 250 American Indian children have been placed with families in 20 States, mostly in the East. The children who have been placed in adoptive homes through this program are from 14 States, though most are from Arizona and South Dakota. They have ranged in age at the time of adoptive placement from birth to 11 years. The majority, however, were under a year.

The League is operating the new exchange as a demonstration project with funds from the Field Foundation, the American Contract Bridge League Foundation, Bureau of Indian Affairs, and private contributors.

The Committee on Adoption Law, Council of State Directors of Children and Youth, American Public Welfare Association (APWA) and the Adoption Subcommittee, Family Law Section, American Bar Association (ABA) met as a joint committee in May in Philadelphia to consider how the 1953 Uniform Adoption Act drawn up by the National Conference of Commissioners on Uniform State Law can be made more acceptable to State legislatures. (The National Conference is an organization of about 70 lawyers, most of whom are appointed by State Governors, who meet each year to draft proposals for State laws.) Although APWA and ABA have recommended the act to the States, only two—Montana and Oklahoma—have enacted it.

The joint committee at the Philadelphia meeting discussed amendments to the act relating to such topics as greater protection for the child placed for adoption, termination of parental

rights, the adopted child's inheritance rights, the right of a minor to consent to adoption, and the handling of amended birth certificates.

Suggestions for changes in the act which came out of the meeting are being drawn up as a draft by the Committee on Adoption Law for approval by APWA and ABA. The final recommendations will be passed on to the National Conference of Commissioners on Uniform State Laws.

In Toledo, Ohio, the public school system, in cooperation with licensed adoption agencies and the Auxiliary to the Lucas County Academy of Medicine, is sponsoring discussion groups for prospective adoptive parents through the Family Life Education Center. Participants referred by the agencies attend five sessions (one a week) on these topics: becoming a family through adoption, understanding the baby, caring for the baby (two sessions), and being adoptive parents. Staff members of social agencies and members of the medical profession in the area conduct the sessions.

The Family Life Education Center was established by the Toledo Board of Education in 1939, in cooperation with the U.S. Office of Education and the State Department of Education. It operates a partly self-supporting pre-school center, offers study courses in family relationships to community groups, provides special consultation services in family life education to organizations and individual clients, and maintains a resource library.

Cost analysis

Cost analysis can describe what the costs of a day-care center are but it cannot of itself determine what the costs should be, according to the findings of a recently completed study, "Cost Analysis in Day Care Centers for Children," conducted by the Florence Heller Graduate School for Advanced Studies in Social Welfare of Brandeis University, with a grant from the Federal Children's Bureau. The report of the study points out that a center's policy, because it is based on standards of service as well as on costs, determines what services cost.

Efforts by a nonprofit agency to refine its accounting system to obtain compa-

table cost information on the basis of program functions are subject to pitfalls not encountered by profit-making enterprises, according to the report. Rather than a set of detailed functional categories being applied to dissimilar program, it suggests that only broad areas of program service should be compared.

The investigators found that the following factors accounted for differences in costs: organizational structure—half-day programs, for example, are more costly to operate than full-day; salaries, particularly because salaries are the largest cost incurred; number of children cared for; and number of program days.

The most costly part of a cost analysis is conducting a time analysis, the report says, but adds that a cost analysis need not include an elaborate time analysis. A "typical day" profile, such as the one prepared for the study which breaks down daily schedules by functions and estimates the time spent by staff members on that basis, could be used, it suggests.

The purpose of the 3-year study was to develop and test a method of analyzing the costs of day-care centers on a comparable basis. Data on six day-care centers—three with full-day programs, three with half-day—in the Boston area were assembled and broken down by costs and functions for each center. Bernard Greenblatt, on leave from the research division of the Children's Bureau, was director of the study from September 1963 to December 1964. The study was completed under the direction of Mildred Guberman.

Correction

Because of an error in the biographical note about Sidney Z. Moss, author of "How Children Feel About Being Placed Away from Home," in the July-August 1966 issue of CHILDREN, the editors owe an apology both to Mr. Moss and to F. Herbert Barnes, executive director of the Carson Valley School in Flourentown, Pa. Contrary to our statement, Mr. Moss was not director of the school. He was director of its case-work services from September 1964 to July 1965. The editors wish to make clear that the views expressed in the article are Mr. Moss's and not necessarily those of the school.

IN THE JOURNALS

Children in divorce

The rights of children "as interested and affected parties" in divorce action are gradually being "identified, protected, and fulfilled" in Wisconsin, according to Robert W. Hansen, circuit judge of the Family Court of Milwaukee, writing in the Spring 1966 issue of the semi-annual *Journal of Family Law*. ("The Role and Rights of Children in Divorce Actions.") There, he says, the law provides for a family court commissioner to try to effect reconciliation, to investigate the case, to advise the court, and to appear in the action as necessary.

On the basis of decisions of the Supreme Court of Wisconsin—one of which is that every child has the right to be represented in a divorce action—the Family Court of Milwaukee has drawn up a 10-point bill of rights for children involved in divorce action which strongly emphasizes the welfare of the children. The welfare of the child, the author maintains, may now be properly considered by a Wisconsin family court judge in "matters other than the question of custody placement."

The author foresees State legislation that will protect the rights of the child in divorce action to economic support. Several counties in the State, including Milwaukee, have already established a system of reviewing compliance with court orders regarding child support, he reports.

The dropout story

The school dropout begins and ends as a misfit and is essentially a friendless boy or girl, 19-year-old Elirik Adam Tecumseh Blom, who has twice dropped out of school, maintains in an article in the July-August 1966 issue of *Southern Education Report*. ("What Makes a Dropout.")

In school the future dropout is outside the "in groups," he says, and finds friends only among other misfits. He

truants frequently at school and at home. At this point, the author maintains, if the parents would heed the signs and take up the problem with school officials immediately, later trouble might be averted. If they do not, the misfit continues to truant until he drops out or is expelled.

Once free of school, however, the dropout is soon bored and cannot find satisfactory work.

The dropout who returns to school is not prepared for what he must face, the author points out. Most teachers will be kind at first, but fellow students will not—they will "rag" him constantly. "There is no charity, no kindness in youth for their own kind." Yet it is not student ragging that drives him away again, but the school's nervous vigilance where he is concerned which keeps him from forgetting that he is a returned dropout. With no one to turn to, he very often leaves school again.

Fetal malnutrition

Underweight mothers seem predisposed to produce infants with fetal malnutrition and the reason may be linked with their diets, according to a study made at the Royal Victoria Montreal Maternity Hospital and McGill University and reported in the April 1, 1966, issue of the semimonthly *American Journal of Obstetrics and Gynecology*. ("Fetal Malnutrition: Its Incidence, Causes, and Effects," by Kenneth E. Scott, M.D., and Robert Usher, M.D.)

The authors base this conclusion, and others, on a study of 3,714 infants delivered at the Montreal hospital, 7.4 percent of whom showed mild, and 2.6 percent marked, fetal malnutrition. Their birth weights were below normal though their periods of gestation had been full term. The authors also found that about 45 percent of the brothers and sisters of the malnourished infants had also been below normal weight at birth though full-term babies.

From their study, the authors also

found that the incidence of fetal malnutrition was unaffected by the season, parental height, maternal age, sex of infant, fetal-placental weight ratio, socioeconomic status, the mother's history of abortions or stillbirths, or by toxemia, post-maturity, or maternal health. The incidence was significantly higher, they report, in primiparous mothers and in those who had received poor antepartum care, or had experienced prolonged ruptured membranes, abruptio placentae, or plural births. These mothers also tended to weigh less than the mothers of the normal infants.

Mothers under strain

Reporting in the July 1966 issue of the *American Journal of Orthopsychiatry* on a comparative study of mothers of healthy and unhealthy children, S. Thomas Cummings, Helen C. Bayley, and Herbert E. Rie, say their findings bear out previously reported clinical observations that the mother of a child deficient in health or in adaptive ability experiences psychological strain. ("Effects of the Child's Deficiency on the Mother: A Study of Mothers of Mentally Retarded, Chronically Ill, and Neurotic Children.") Their report is based on a study of 240 mothers of four types of children—mentally retarded, neurotic, chronically physically ill, and healthy—divided evenly. All were from intact families and had other children. They included both white and Negro women whose social backgrounds ranged from upper lower class to upper middle class. The ages of the children ranged from 4 to 13 years. The mothers were rated for dysphoric affect, self-esteem, interpersonal satisfactions, and attitudes toward child rearing.

All the differences were in the direction predicted—mothers of deficient children had higher levels of psychological discomfort and social alienation than did those of healthy children.

The authors conclude that if we wish to conserve the most important manpower resource we have—the ability of parents to care for their children—we must find ways of helping the parents of deficient children avoid developing personality characteristics which would "attenuate their ability to offer all of their children psychological climates conducive to their optimal ego development."

READERS' EXCHANGE

MOSS: Child placement

The literature of child placement reflects the importance of preparing both child and parents for the separation and emphasizes the effect of the separation on the child and the anxiety which must be dealt with throughout the placement. The consequences of not preparing child and parents for separation are well documented by Sidney Z. Moss. ("How Children Feel About Being Placed Away from Home," *CHILDREN*, July-August 1966.) The cases he cites further evidence that a children's agency service must focus its attention on the parent-child relationship. The current emphasis on placement as part of child welfare services should bring about greater emphasis on work with the parents of children in placement as well as with children.

The child welfare concept as defined by the Child Welfare League of America and the Children's Bureau has received some stimulus from the 1962 amendments to the Social Security Act. The amendments encourage cooperation between public assistance and child welfare in long-range planning for children and their families and emphasize prevention. Long-range planning has definite implications for the child-care field. Early diagnosis and prognosis are required to establish the ability of the parents to meet the needs of children in their own homes; to rehabilitate families whose children require or are in placement; and to determine whether parents will be able to resume the care of their children or whether the children will require permanent foster care or adoption.

The lack of a pattern for long-range planning is responsible for many children remaining indefinitely in "temporary care." The problem is aggravated by the increased number of children in placement because of neglect and abuse, any of whom will never be reunited with their families. Though some are

free for adoption, adoption is not a realistic goal for them because of race, age, or emotional problems. Not all children in need of permanent foster care will be able to use foster-home facilities at the time of placement or throughout the placement period. Some may require residential treatment before placement or during placement or day care as a support for foster-family placement.

Such a free and flexible flow of services is possible only if an agency is oriented to the different needs of children rather than to a single function or existing facilities. Agencies will have to develop comprehensive programs modeled after a general hospital, where specialties function as a cooperative network. All services for the individual child must be planned and provided for continuously. The agency that develops a helpful relationship with the child and family will have to act as the "anchor" to assure the achievement of the goals for the whole family. The comprehensive services must recognize that clinical pathology and social problems are inextricably intertwined; they must follow new patterns of cooperation among agencies. To establish them calls for a change in emphasis from function to service.

Leon H. Richman

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BRODY: Author's correction

My essay-review, "The Developing Infant," in the July-August 1966 issue of *CHILDREN* on Rene A. Spitz' "The First Year of Life," contains an unfortunate error of omission Spitz' observation (p. 81) about the infant's continuous staring at the mother's face from the moment she enters the room

until the end of nursing referred to in infants up to 3 months of age. My contrary observation was thus meant only to refer to infants of that age and not to refer to infants in all of the first year of life.

Probably the error slipped though because our films show that the frequency of eye contact between mother and infant during feeding is low in most cases throughout the first year of the child's life.

Sylvia Brody

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CHENEY: Parental rights

Kimberly Cheney's timely article questioning the adequacy of legal procedures in the newly developing area of protective services draws attention to the difficulty of properly protecting children without invading the constitutional rights of the parents. ["Safeguarding Legal Rights in Providing Protective Services," *CHILDREN*, May-June 1966.] One reason for this difficulty is that while parental rights have been pretty well defined by legislatures and courts, no one has defined the rights of children.

Leading opinions in custody cases, which have reached the highest courts of many, if not all, of our States, are liberally sprinkled with phrases stressing the courts' obligations to act as *parens patriae* in protecting the "best interests" of the children involved. Yet, invariably, in each case the decision itself is based not on the "best interests" of the child but on whether or not the behavior of the parent or parents has been such as to constitute a *forfeit* of their—the parents'—rights.

Mr. Cheney is concerned, as are many of us, with the lack of certainty as to what constitutes neglect of a child. Lack of certainty as to the basic elements of neglect makes it hard for the protective services to know when to intervene, for the courts to judge fairly between the constitutional rights of the parents and the ill-defined needs of the children, and, last but not least, for the parents, whose own judgment may or may not be adequate, to know what is expected of them.

Isn't it time for community action to develop a series of criteria as to the basic rights of all children? If this is

done, then the finding that a child is a neglected child can be based on the absence of some important aspect of a child's rights rather than on the failure of the parent to live up to a particular community's expectations.

Mr. Cheney comments, with apparent approval, about New York's procedures which, he says, provide parents with counsel. I wish his comments were warranted, but I regret to say that far too often the parents are not represented by counsel. It is the child who is now provided with counsel, at least in New York State Family Courts. Admirable as this new procedure is, it only highlights the difficulty in protecting the rights of the parents as well as the, as yet undefined, rights of the child.

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COLLINS: Day care a social utility

The neighborhood approach to day care as reported in Alice H. Collins' article, "Some Efforts to Improve Private Family Day Care" (CHILDREN, July-August 1966), is both imaginative and realistic—imaginative because it is an attempt by a social agency to find a way of improving day care through community involvement, and realistic in recognizing that family day care is essentially a neighborhood phenomenon already in existence and giving every indication of continuing to exist with or without benefit of social agency intervention.

A study done by the Community Health and Welfare Council of Hennepin County (Minneapolis) in 1962 indicated that nearness to own home ranked in importance above cost and quality of care with the 100 mothers interviewed. The study further revealed that 82 percent of the children in the sample had been placed in day care within their own neighborhoods.

Just how to relate ourselves to this neighborhood system is perhaps the number one dilemma facing the child welfare agencies. How do we translate into action our expressed concern that good day care be given all children who need it?

It is impossible to apply the techniques of foster placement as a problem-solving resource for children to the provision of what Alfred Kahn in a recent address to the National Conference on

Social Welfare called a social utility—day care for the many thousands of children for whom day care is a necessary and normal part of their day-to-day living. Is this the reason we have turned to various other aspects of day care?

We are urged to look on day care as a treatment resource—for the retarded child, for the overburdened, inadequate mother; as a socializing experience for underprivileged children; or as a means of preventing full-time placement. All well and good, all necessary and laudable services, but are we dodging the issue—taking refuge in our comfortable, knowledgeable role of selecting homes, placing children, and giving casework service to them and their parents? A glance at the literature will reveal our preoccupation with these phases of day care rather than with how to improve the care given to the thousands of children of working mothers. Have we heeded too well the injunction not to look on day care only as a service to the working mother and her child?

Roberta Kendrick
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Minneapolis

Child welfare's stepchild

The Day Care Exchange Project as described by Alice H. Collins appears to have raised more questions than it has answered. Friendly House, the sponsor of the project, is to be congratulated for entering into a family day-care program, a type of care which appears to be the stepchild of child welfare.

It is extremely helpful to have a look at private, nonregulated, unsupervised family day care, for it gives us an opportunity to assess child-rearing and child-caring practices in their "natural state." Agency intervention so alters practices, attitudes, and verbalization that we cannot safely generalize from agency caseloads.

The matter of the project's design should be mentioned. It is illustrative of the quixotic nature of social work research. A neat plan was made to meet an obvious need. It was based on the known and accepted methods of surveys, casework, and group work. What could be simpler? But the group to be studied would not conform to the plan! New questions needed answers and plans had to be reformulated. It is ever thus, in research with people.

Without underestimating the importance of the relationship between the natural mother and the day-care mother in ensuring continuity of care, I wonder whether another factor outside the purview of this Portland project is no crucial in promoting stability. I refer to agency financial support.

If family day care were to have adequate financing, many of the problems or quixotic withdrawal of the child b the mother would be eliminated. When a mother knows that her child is in supervised, agency-approved home and that the care is partly subsidized, she is likely to work out minor irritation and to leave the child there, even if there are changes in her life while would otherwise encourage her to withdraw the child.

Elizabeth A. Verno
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Day Care, Day Camps, and Institution
Bureau of Child Health, New York
City Health Department

for parents

SOME SPECIAL PROBLEMS OF CHILDREN—AGED TWO TO FIVE YEARS. Nina Ridenour and Isab Johnson. Child Study Association of America, 9 East 89th Street, New York 10028. 1966 (Revised edition 61 pp. 1 to 9 copies, 75 cents each; 10 to 24 copies, 60 cents each; rates for larger quantities available on request.

LEARNING TO LOVE AND LET GO A guide to helping children become independent. Greta Mayer and Mary Hoover, Child Study Association of America, 9 East 89th Street, New York 10028. 1965. 61 pp. 1 to 9 copies, 75 cents each; 10 to 24 copies, 60 cents each; rates for larger quantities available on request.

RECOMMENDED READING ON SEX EDUCATION. Child Study Association of America, 9 East 89th Street, New York 10028. 1966. 16 pp. 25 cents (plus 10 cents postage and handling Discounts on quantity orders.

A listing of 36 publications divide into sections for adults, for children and young people (ages 5 to 9, 9 to 13 to 15), and for older adolescents and young adults.

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

RECENT DEMOGRAPHIC TRENDS AND THEIR EFFECTS ON MATERNAL AND CHILD HEALTH NEEDS AND SERVICES. Eleanor P. Hunt. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 20 pp. 20 cents.

An analysis of population trends in the United States in relation to present and future needs for health services and personnel. Includes charts and tables showing infant and maternal mortality rates in the United States for 1915-1963, population projections for 1963-1975, and total number of births (live and still) and percents in urban and rural areas by color for 1950 and 1963.

OUR CHILD FROM 6 TO 12; AND MOVING INTO ADOLESCENCE: YOUR CHILD IN HIS PRETEENS. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 324. 1966. 98 pp.; and CB Publication No. 431. 1966. 46 pp., respectively. 25 cents each.

The first is a new family-centered guide for parents—prepared to replace a

publication brought out under the same title in 1949. It centers on the physical, emotional, social, and intellectual growth and behavior of normal 6- to 12-year-old children. Appendices describe physical and emotional problems which may occur in children in this age group and the kinds of services available in most communities for parents and children.

The second, prepared as a supplement to the first, discusses preadolescence and some of its aspects which often concern both parents and young people.

PROJECTS FUNDED UNDER THE CHILD WELFARE RESEARCH AND DEMONSTRATION GRANTS PROGRAM; AND PROJECTS FUNDED UNDER THE MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES RESEARCH GRANTS PROGRAM. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 13 pp., and 11 pp., respectively. Single copies free on request from the Bureau.

These publications briefly describe the research grant programs of the Chil-

dren's Bureau and list projects completed or under way. The first lists 10 completed or terminated child welfare research or demonstration projects supported from March 1960 to June 30, 1965, and 55 such projects still being supported as of June 1965. The second lists 61 projects, current as of June 30, 1965, which are focused on the health status of and services for mothers and children.

RESEARCH RELATING TO MENTALLY RETARDED CHILDREN. No. 1 of a series, Research Relating to Special Groups of Children (revised). Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 126 pp. 65 cents.

This publication lists 858 research projects on mental retardation, all reported to the Children's Bureau Clearinghouse for Research in Child Life from 1949 through 1965, with information on publications reporting on the research. Seventy-seven of the projects included were first reported in 1935.

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First aid for an emotional crisis comes to this child as the comforting arms of an adult. It may be all he needs to cope with one of the minor crises that are part of every child's daily life. But for far too many children emotional disturbance is chronic, deep, and severely handicapping. Three articles in this issue discuss programs for helping such children in the community and in school. (Pages 221, 227, and 232.)

children

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ADA M. DANIELS

School nurses are in a crucial position to help young people straighten out a confusion of fears, misinformation, and worries connected with the physical and emotional changes of adolescence—a confusion which often leads to tragic mistakes. Unfortunately, many nurses who work in schools are not equipped with the special skill and understanding needed to provide the kind of help confused young people require. Recognizing this fact, the Child Study Association of America (CSA), at the request of the Colorado State Department of Public Health, and with encouragement and financial support from the Children's Bureau, has been carrying out a demonstration project in Denver to train nurses in the schools to lead small groups of adolescents in discussions focused on the issues troubling them. The purpose of the project is not only to increase the nurses' skills as group discussion leaders, but also to broaden their understanding of adolescents generally and increase their ability to deal with them sensitively.

Public health nurses assigned to the schools in Denver have for some time been conducting education programs in the junior and senior high schools. Prior to the CSA project, these programs usually consisted solely of showing a film on menstruation to the girls and one on human growth and reproduction to both boys and girls, following the showings with brief discussions of the facts presented.

training SCHOOL NURSES to work with groups of ADOLESCENTS

ented in the films. While some of the nurses realized that many of the young people were confused about how to apply the biological information they were getting to the situations they confronted in their day-to-day lives, the nurses did not encourage discussion of the personal and social issues connected with the facts presented. The CSA project has concentrated on preparing some of these and other nurses to help young people understand better their own physical, emotional, and mental development and to make more thoughtful behavioral choices.

The project got under way in January 1966. Fourteen nurses, varying greatly in age and experience, were selected to participate in the initial training program: three school health nurses, seven public health nurses who had been assigned to part-time duty in the schools, two consultants from the State Department of Public Health, one nurse from a clinic for adolescents, and one nurse from the University of Colorado faculty. Since in the Denver public schools sex education for boys is customarily handled by a physician, all the nurse-trainees were prepared to work with groups of adolescent girls.

The "issue-focused group discussion" method was chosen as a means through which the young people, under skilled leadership, could exchange ideas about themselves and their peers, acquire correct information relating to their bodily functions and their emotional and social needs, and begin to apply this

information to themselves. Since adolescents frequently have difficulty discussing their problems with adults, whether parents or teachers, a method which enables them to talk to each other about the things that bother them, under the guidance of an objective, knowledgeable adult, is especially appropriate for them.

The underlying purpose was to help the nurse-leader increase her understanding of adolescents, the issues they are most concerned about, and the range of appropriate behavioral choices available to them. These issues the project planners saw as having to do with the physiological and emotional changes adolescents are undergoing—especially those connected with puberty—and with ways of coping with them, such as personal grooming, boy-girl relations, and educational and vocational planning.

Using physiological and emotional changes as broad topical categories, the nurse-leaders were asked to suggest agenda for a series of four to eight discussion meetings of about 50 minutes each, which could serve as a framework to contain the often impulsive, scattered thinking of adolescents. Then, in practice discussion groups, they offered the young people an opportunity to select some specific issue within this framework for the focus of each session, and helped them explore the personal meaning of their questions and remarks.

To do this effectively, the nurse-trainee had to pro-

vide an atmosphere of objectivity and tolerance and draw on her knowledge about life and the complexities involved in behavioral choice as well as on her broad range of information about how the body functions and how this affects human emotions. In giving factual information, she had the use of many visual aids, but the discussion was not limited to the facts these presented, as it had been in the past.

The program design

The training program was based on a design previously used in other training programs of the Child Study Association of America.¹ This consisted of an initial 2-week institute, followed by a period of supervised field work, a 1-week followup institute, and another period of supervised fieldwork. Supervision was provided by mail and through intensive conferences with the individual trainees prior to the followup institute. Supervision by mail is, of course, an unusual method, but the training staff of the Child Study Association of America, based in New York, has had many years of experience with it.¹

The first 2-week institute was held in January. The instructors consisted of two staff members of the Child Study Association of America aided by representatives from the Denver school system, the local welfare department, the University of Colorado Medical Center, and the University of Maryland School of Nursing. During the first week, the nurses were given a review of child development theory from early infancy to adulthood, with special emphasis on early puberty and adolescence.

The second week of the institute was devoted to the specific methods of conducting issue-focused small group discussions with adolescents. As a demonstration, the film "Human Growth and Development," often used in school programs of sex education, was shown in a local junior high school auditorium to a large group of girls, after which the nurse-trainees divided the audience into groups of 10 to 15 students each and led discussions, using the techniques to which they had just been introduced.

In these discussions, the girls confronted the nurses with 80 different questions, revealing worries or misapprehensions about a whole range of biological subjects, from menstruation—cramps, moods, permissible activities—to venereal disease, miscarriage, conception and pregnancy, sexual intercourse, and male physiology. For example:

"Do boys dream about sex and then wet the bed?"

"How do babies come through that small opening?"

"How do birth control pills work—don't you take them by mouth and they settle in the vagina so that when the egg comes by they swallow it?"

"Why are boys more excitable sexually than girls and how can we control them?"

"Why do parents feel funny about talking to their children about these subjects?"

"Why do they wait so long before showing us these kinds of films?"

The nurse-trainees' reactions to this experience ranged from an anxious sense of being overwhelmed to a sense of elation at finally getting at what the had been feeling all along in their daily work with students: that the problems really troubling the young people who came to them were below the surface of the physical complaints they presented. Some of the nurses expressed doubt about being able to handle such emotionally charged questions within a school, with its many restrictions on what could be discussed with young people. Yet, they all expressed eagerness to learn ways of coping more effectively with the fears and misconceptions that had been so openly expressed.

While the trainees seemed to have confidence in their ability to deal with the usual kinds of question raised in relation to menstruation and other health-related topics, many of them expressed consternation at the prospect of having to handle such delicate subjects as "the pill," abortion, and premarital sexual relations should questions around these issues arise. All, however, agreed that adolescent girls need basic information concerning their bodily processes.

Handling specific issues

Using menstruation as a topic that all the trainees felt at ease in handling, the CSA staff demonstrated how such a topic could be dealt with in a small discussion group, in contrast to the way it might be dealt with in a class on hygiene. With the mood swings of the menstrual cycle taken as an example, the trainees were helped to look at the physiologic facts—hormonal changes, water retention, and so forth—that the girls needed to know about to be aware of the normal internal changes that may cause them to feel peculiar, either before or during menstruation. The nurses were helped to see that after giving the girls such factual information about mood changes, they could help them explore the feelings they experienced at these times—depression, irritability, hypersensitivity, tearfulness, negativism, withdrawal, emotional outburst, quarrelsomeness and how these feelings could affect their relationships.

with other people; and that then they could encourage the girls to express how, as individuals, they felt about menstruation—whether just “crummy,” or resentful of the limitations it puts on going swimming, or deeply angry at its messiness—so that the girls would come to realize that there are many different normal physical and emotional reactions to menstruation and both constructive and destructive ways to cope with such feelings.

The trainees were then helped to see how they could use this kind of approach to the girls’ questions regarding issues having moral implications. Questions about induced abortion, for example, could be dealt with first by giving the girls the facts about how pregnancy takes place, the medical difficulties and dangers of interrupting a pregnancy, and the emotional consequences to the girl who undergoes such an experience and to her parents. The girls could then be encouraged to consider the alternatives—what they at their age were really ready for in regard to relationships with the other sex. Similarly, questions about contraception could be dealt with in terms of the biological facts, the medical supervision necessary to make it effective, and the emotional conflicts and the behavior choices that the use of on-contraceptives poses for a girl.

In this way the nurses were helped to see that all the issues of crucial concern to young people—especially boy-girl and parent-child relationships—need to be explored in respect to where the girls are in their emotional and physiological development, and what they need to know and think about to move on constructively to the next phase of their lives.

Some of the nurses expressed concern about the possibility of giving information to young people that might conflict with what their parents were telling them at home. Many of the girls in the schools they were assigned to came from ethnic backgrounds having different cultural mores and beliefs from their own. For example, some of the girls had been brought up to believe it was dangerous to bathe during the menstrual period. The trainees were helped to see that a contrary view could be presented as new medical information that had not been available to the girls’ mothers when they were growing up and as such would not be likely to create a family conflict.

Field practice groups

The requirement for the first supervised fieldwork training period was that each nurse lead a group of from 15 to 20 girls for from 4 to 8 weekly sessions.



Adolescents, like these high school boys and girls, are often confused by the changes they are undergoing. In Denver, school nurses are leading adolescent discussion groups to help young people understand the meaning of such changes.

Several of the nurses recruited groups in the school in which the 1-day demonstration program had taken place. Some organized groups in schools to which they were regularly assigned. A few of the public health nurses who had no regular school assignments recruited groups in parochial schools, which had previously hesitated to permit sex education programs. Others formed groups of older adolescent girls who were serving as volunteers in hospitals.

The nurse-leaders of each of these groups were supervised by mail by the CSA training staff. Each nurse-leader mailed a detailed report of each group meeting to her supervisor as soon after the session as possible, giving information on the basic content of the session, the group interaction, the leader’s activity, and the problems that arose. She received in reply comments about her leadership and suggestions for handling the various issues brought up by the group members.

Most of the nurses had some initial resistance to writing reports that required so much more detail than the brief topical reports they were used to. They also had clerical problems, since the school administrators were not all prepared to give the additional clerical help or time they needed to produce the reports quickly. Despite these difficulties, the nurses were able to profit from the points made in the super-

visory responses to their reports and to improve their skill.

At the end of the first fieldwork training period, each trainee had a personal conference with her supervisor to discuss her leadership problems directly.

As had been expected, the issues brought up by the girls in these practice discussion groups fell under a few major themes. First and foremost was boy-girl relationships. This included such questions from the girls as how to behave on dates, how to handle the sexual advances of boys, and how to deal with their own needs for affection and popularity and their own sexual promptings. These questions gave the nurses an opportunity to bring in information about physical development, the facts of reproduction, and the consequences of sexual exploration. Most of the nurses learned not to moralize, but instead to help the girls think through the implications of what they were saying about their own behavior.

Next most frequent theme was how to discuss relationships with parents. Why were parents so "old-fashioned" in their thinking? Why couldn't girls go out on dates at ages 14, 15, or 16, or wear certain styles of hairdress, clothes, makeup? Why were parents so uninterested in listening to the girl's side of the story and so hard to talk to? Some girls expressed the feeling that their parents were too involved in their own daily problems to pay attention to their daughters' needs.

The nurses were usually able to help the girls recognize that many of their complaints about their parents were related to a difference in the girls' and the parents' perceptions of their maturity and their readiness to handle the kinds of experience the girls actually were having trouble with—their inability to know how to deal with a boy on a date, for example. They also helped the girls discuss ways in which they could handle conflicts with parents more constructively. During these discussions, many of the girls gave evidence of developing a more positive perception of their parents—some even to the point of sympathizing with their hard lot.

While most of the groups consisted of girls from a variety of backgrounds, two consisted chiefly of girls who had experienced severe deprivation—emotional, economic, and cultural—and who had exhibited serious behavior problems in school, truanting, getting into fights, and actual delinquent acts. Some were on probation from the court. The girls in these groups raised questions about venereal disease, pregnancy (which several of them had already experienced), parental cruelty or neglect, and their

own need to rebel. At all times they were accorded support and respect by the nurse-leaders, and for the most part by the other members of their group.

With this unaccustomed acceptance and with the information and guidance given them by the nurse-leaders, some of these girls began to question the behavior choices they had made in the past and to think about the advantages of staying in school and making realistic vocational plans. Even those whose behavior in the group did not change gave evidence of more responsible behavior in school—less truanting, for example—and a growing capacity to examine their behavioral choices. The marked effect of a group experience on some of these girls caused a real stir among the school personnel, the probation officers who had tried to deal with them in other ways, and the nurse-leaders themselves.

At the end of the series of practice sessions, some nurses gave their girls questionnaires—to be returned unsigned—asking whether the meetings had been helpful. About 85 percent of them replied; all, favorably. One girl answered:

Yes, in our normal health class, we can't ask the question that bother us or we don't understand. . . . It's really nice to have had someone who understood our feelings. . . . I mean to know that we are human and not wild and unreliable.

All the returns gave an affirmative response to the question of whether *all* boys and girls in the 9th and 10th grades should have an opportunity to participate in such groups. Some indicated that the group sessions should take place twice a week for a semester all, that there should be more sessions in each series than there were.

Followup program

The second part of the training program took place in April 1966, and involved a week's followup institute, preceded by intensive supervisory conference with each trainee. In this followup period the trainees exchanged information about their experience and raised whatever questions they had about their. They also examined records of discussion groups of adolescents from another CSA training program to study the leadership methods.

All 14 of the trainees participated enthusiastically in all or part of the followup sessions although at the beginning of the program in January some had expressed doubts about having the time to do so. As they discussed their practice group experiences, it became obvious that they had applied the lesson

from the original 2-week institute with a great deal of imagination and flexibility—in recruiting their groups, in interpreting the program to school administrators, teachers, and parents, and in leading the groups—and had made a noticeable impression on other professionals in the schools, on the parents, and on the girls. True, the degree of skill and understanding in group leadership the nurses had acquired varied with the individual. In the followup program, however, they all discussed freely their own shortcomings and areas of confusion.

Leadership problems

Certain basic leadership problems were brought out in the followup sessions.

The nurses who had led groups composed of girls from diverse ethnic and socioeconomic backgrounds had shied away from discussing subjects that would reveal differences in family customs and behavioral attitudes, regarding these as potential sources of conflict among the group members. For example, some girls from Spanish-American families were not permitted to go out with boys until a much later age than usual in most other American families. Knowing this and fearing that the girls of Spanish cultural background and their families' standards and practices would be ridiculed by the other girls, the nurse-leaders in these groups did not encourage the young people to talk about their difficulties with their parents over restrictions, although such conflicts came up in their groups as in the others.

As the reasons for this hesitancy were examined in the followup seminar, the nurses recognized that they themselves and not necessarily the girls in their groups were the ones who felt that standards different from their own were "inferior," and that a free discussion among the students about their experiences might have revealed many diverse practices in families generally, all with both positive and negative aspects. For example, the practice group discussions had revealed that many girls were permitted almost limitless freedom, with almost no parental restrictions set on their behavior, and that the girls themselves often attributed this to lack of parental concern. Thus the nurses came to see that the way in which they perceived differences within a group could affect their skill in leadership, that if they could regard the young people from diverse backgrounds as being able to contribute to the broadening of one another's points of view, they could use their understanding of these differences constructively to

help them cut through the economic and cultural barriers to mutual understanding.

Another factor that had confused and shocked some of the nurses was the degree of family distress revealed by some girls from "nice, middle-class homes." They had had no idea so much real trouble often lay hidden behind the overlay of middle-class financial comfort, education, and opportunity. In the followup sessions, they came to recognize that the kind of accepting group atmosphere they had provided the girls may have enabled some of them to open up freely about their feelings for the first time. Some of the nurses said they had become much more aware than they had previously been of the counseling needs of young persons from "average" families, as well as of those from families with more obvious problems. They realized, however, that they themselves were not equipped to deal with serious family problems and that the group discussions were not intended for this.

Many of the trainees also had difficulty in maintaining a balanced viewpoint, one not identified too closely with either the young people, their parents, or the school authorities. To help them with this aspect of leadership skill, the staff again emphasized the importance of encouraging the free interchange of differing points of view.

To broaden their perception of intrafamily relationships, the nurses were asked to identify the issues bothering parents of adolescents as they reviewed the records of parent groups led by trainees in earlier CSA programs. They were also given an opportunity to discuss ways of counseling parents individually, since in their regular jobs they worked with parents as well as with young people.

The staff's emphasis on the emotional implications of the issues adolescents are concerned with was not intended to overshadow the importance of the factual knowledge that nurses bring to their work with young people. However, some trainees had tended

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to go overboard for a time in exploring feelings and to neglect the presentation of factual knowledge about health needs. Restoring the balance proved to be a major supervisory task.

The followup seminar ended with consideration of ways to improve communication between the nurses and the other professional persons—teachers, guidance counselors, school administrators—who were also working with adolescents and parents within the school system. Some of the nurses had encountered some difficulties with school personnel who had failed to understand the purpose of the program.

Nevertheless, one of the most rewarding results of the program has been the positive impression it has made on the agencies and schools in which the trainees worked. Some of the nurses have since been asked to lead groups of unwed adolescent mothers. Others have been asked to use their learning and teaching materials acquired in the program in supervising the work of beginning school nurses. School guidance counselors, social workers, and administrators have met with the nurses to learn more about the goals of the group leadership program and have expressed great interest in helping promote further work in this area.

Some of the trainees were unable to lead new groups under supervision between April 22 and June 1, when the program officially ended. However, those nurses who did take on new groups moved ahead in interesting ways. Two led groups of educable retarded adolescent girls. In these groups the same issues came up as in the groups of normal girls, and in much the same way, but the nurse-leaders had to exert more authority to keep the girls' attention focused on the topics under discussion, had to be more directive in their leading questions, and had to reemphasize, in simple, concrete language, the major points that had been made in the discussion.

Some lessons

What was learned from this program that might be retained, or profitably be changed, in future programs?

First, it became clear that the success of such brief, intensive training necessitates careful selection of the nurses to be trained. Whether young and fresh out

of nurses' training school, or older and experienced, the trainees should have a strong desire to participate in this type of program. Reluctant or overburdened nurses, not particularly interested in adolescents, or nurses satisfied to relate only to the physical needs of young people are not likely to make constructive use of the experience. Trainees should also have some previous knowledge of child development and family interaction, as so brief a period of training can serve only to refresh the nurse in her knowledge and to resensitize her to the complexities of daily family living from which the problems of young people stem.

Hindsight suggests that more specific interpretation of the purposes of this kind of issue-focused small group discussion program prior to the program's initiation should be afforded to other professional people in the same setting—in this instance school social workers and school guidance counselors. Some overlap of function may be unavoidable, but if the nurses' colleagues from other profession understand that the nurses will be bringing a new dimension to their responsibilities for health education, they will be able to see the program's potential.

If mail supervision could be supplemented by more frequent personal consultations and some staff observation of the nurse's group leadership, the trainee's learning might proceed further. Plans are now under way to train some of the nurses from this demonstration program to supervise other trainees from their own area. This should make more direct supervision possible for any future program of this type in the Denver area.

The challenges to both the trainers and trainees in this project were to take a fresh approach to the issues young people are struggling with today, at tempting to view them as the young people do themselves, and to develop methods of helping the young people cope with their problems more effectively. Their experience in the project revealed the nature of the issues young people are concerned about and the ability of school nurses to deal with them in truly meaningful way.

¹ Cohen, Franklin; Rabinow, Mildred: Consultation process in training for mental health education: the use of correspondence and observation. Presented at the National Conference on Social Welfare, Atlantic City, N.J., May 1965.

the role of the NUTRITIONIST in an ADOLESCENT CLINIC

S. L. HAMMAR, M.D.

The use of an interdisciplinary approach can often be an effective method of handling some of the special problems that adolescent patients present. The University of Washington Adolescent Clinic is a medical clinic that has used such an interdisciplinary approach in providing diagnostic services and health supervision to teenagers. Because many of the problems encountered in this age group relate to nutrition, the nutritionist has been an important member of our clinic since its inception in 1959. In the ensuing time, we have had the opportunity to explore the many ways in which we can use her professional skill, not only to assist in the care and management of adolescent patients, but also to enhance our understanding of this age group.

It is difficult to define the role of the nutritionist in our clinic because her position is not static but, rather, one which is flexible and dynamic. She has been given sufficient latitude to create, define, and fulfill her own unique role, drawing upon her previous training and experience. Thus she has been encouraged to use inventiveness and originality in approaching her responsibilities. Since the nutritionist is a member of a multidisciplinary team, she is to be able to communicate meaningfully with the other professional persons—representatives from the fields of medicine, social work, psychology, and public health nursing.

Perhaps the best way of describing the nutri-

tionist's role in our clinic is to define the way in which she relates to the members of the other disciplines on the team.

Nutritionist and physician

When asked by the physician to participate in the evaluation and treatment of an adolescent patient, the nutritionist functions in four ways: (1) as an investigator; (2) as an advisor; (3) as a therapist; and (4) as an educator.

As an investigator: Customarily, the nutritionist in our clinic interviews the teenager without his parents, though at times she may need to see other family members to obtain adequate information. Her effort is to secure an accurate assessment of his eating habits and dietary intake.

Communicating effectively with a teenager involves an understanding of the normal behavior of adolescents, their manners and mode of talking, and their typical habits to determine whether or not the patient deviates significantly from his age group. It also requires the nutritionist to have an understanding of the cultural patterns in the patient's social milieu.

The physician is usually less interested in a detailed accounting of the patient's caloric and nutrient intake than he is in the nutritionist's own observations of the teenager. Therefore, the nutritionist's report

includes information on: how the boy or girl relates to her as an adult; his attitude toward food; whether there are family problems centering on food or mealtime; and his reliability and accuracy as an informant. She tries to evaluate whether or not the adolescent is maturing normally in his eating patterns and is beginning to assume some responsibility for his food selection and nutrition.

During the course of an interview, some adolescents bring up problems with the nutritionist that they may hesitate to discuss with their clinic physician. For example, girls with menstrual complaints or who are concerned about their sexual development may avoid bringing these subjects up with a male doctor, but feel free to talk about them to the nutritionist because she is a woman. The nutritionist can explore such problems sympathetically with the patient, making it clear that they will be brought to the attention of the physician.

As an advisor: The nutritionist recommends to the physician whatever changes, if any, are indicated in the dietary. In addition, she makes suggestions for instituting such changes. It is not enough for the nutritionist to tell the physician that a teenager's diet is low in iron or in calcium or ascorbic acid. To provide a useful consultation, she must consider some important questions: How does one get the adolescent to accept changes in his diet? What foods are most acceptable to him? What are his food likes and dislikes? How does one reinforce good eating habits in teenagers? What is the prognosis for change and do other members of the family need to be involved or counseled regarding his nutritional problems?

As a therapist: In treating adolescents with problems such as obesity or growth failure, the nutritionist is often called upon to assume the role of a therapist—to counsel and supervise the adolescent with a specific dietary regimen. In our clinic the physician and the nutritionist often see the patient on alternate visits, thus giving the patient more attention than either could give alone. If one is to work effectively with these patients, there must be close supervision and frequent contacts.

We have found that in many instances teenage girls with such problems as obesity may relate better to a woman. Working with an adolescent in relation to the diet often provides an entree for discussing many types of problems related to maturation and growing up. Our nutritionist, for example, in her counseling role often can help an obese girl develop

her social skills and improve her hygiene and grooming. Being a woman, the nutritionist can serve as a good adult model for identification, particularly for the teenage girl who may not previously have had a healthy adult woman to emulate.

As an educator: The nutritionist helps to keep other members of the multidisciplinary team informed of current developments, new ideas, and recent studies in the field of nutrition. She can supplement a team consultation on almost any type of patient or medical problem with information or research data reported in the professional literature. They tend to bring the staff up to date, increase their interest, stimulate discussion, and often produce new and fruitful ideas that can be used in patient management.

Nutritionist and nurse

Although the nutritionist in our clinic accepts referrals only from the physician, who has ultimate responsibility for the care of the adolescent patient, she has ample opportunity to work closely with the staff members from other disciplines, especially the nurse and the social worker.

The nutritionist and the nurse can often reinforce each other's efforts in relation to grooming, hygiene and dietary supervision. The nutritionist can support the nurse's attempts to improve a teenage girl's appearance by making it a point to compliment the girl upon her dress, her hair style, or her makeup thus helping to bolster her ego and to create an awareness of how she affects others. The nurse, on her part, can review with the teenager the nutritionist's dietary instructions. In this way, she is frequently able to detect areas of misunderstanding and confusion that require additional clarification. Her followup contacts provide a means of determining how much nutritional information has been retained by the patient, and whether the patient has sufficient motivation to adhere to the prescribed dietary regimen.

At times, the nutritionist and the nurse find that they can operate more efficiently and effectively through working with teenagers in groups. For example, the nutritionist and the nurse in our clinic have conducted a "self-improvement" group for obese girls. The purpose of such a group is to provide an acceptable atmosphere and to create a situation in which the overweight girl can receive some gratification from interacting with members of her own age group, develop her social skills, and improve her self-image.

The nutritionist and the nurse, working together, provide the girls with dietary education, arrange social activities, enlist the aid of outside speakers, organize field trips, and set up volunteer work projects.

Nutritionist and social worker

In our adolescent clinic, the social worker has contact primarily with the parents of the teenage patients, initially to obtain background information on the family and later to provide short-term counseling, if indicated. The nutritionist and the social worker work together cooperatively in many ways. Often the nutritionist, through her contacts with the adolescent, is able to provide additional insight into the home environment and the intrafamily relationships. It is not unusual for her to uncover problems, once she has established a good relationship with the adolescent, that may not be apparent to the social worker or the physician.

For example, obese adolescents often complain that their parents tend to make it difficult for them to lose weight or to adhere to a diet. Parents of an obese teenager usually need help in recognizing their own contribution to their child's weight problem. Often, in subtle and unconscious ways, such parents tend to undermine the dietary program by nagging the adolescent or belittling his effort to lose weight. They may tempt him with readily available desserts and snacks. The parents of an obese teenage girl, for example, may insist that she be responsible for preparing the family's meals. By maintaining close communication with the nutritionist, the social worker becomes aware of such problems and can discuss them directly with the parents, helping them modify their behavior and attitudes toward the obese adolescent.

Types of problems encountered

The most common types of problems in which the nutritionist becomes involved in our adolescent clinic are the following:

Obesity: This is a prevalent and frustrating disease that characteristically involves a dependent, passive, adolescent girl, who usually has little motivation to lose weight. Obese boys, of course, are seen. Generally the nutritional evaluation involves a diet.

Step 1 is information collecting. The nutritionist

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assesses the patient's normal eating habits, and knowledge of calories and food values, and investigates critical areas that may contribute to the obesity problem, such as the family attitudes toward obesity, the availability of money to purchase appropriate foods, previous attempts at weight control, responsibility for meal preparation, family activities, and exercise patterns. This part of the workup, which may require several interviews with the adolescent, provides a baseline of data on the patient. Such information must be collected before modifications are made in the dietary, in order to determine subsequently whether or not progress has been made.

Step 2 is instructional. This involves providing the patient with a weight-reduction program. Such a program is planned after the nutritionist has conferred with the managing physician and a joint decision has been reached regarding the advisability of attempting weight reduction in the particular adolescent.

With some obese patients, the nutritional evaluation may not immediately, if ever, be followed by the treatment phase. Initially, a direct attack on the weight problem may be contraindicated. This is often the case if food and "overeating" have become a source of serious conflict or stress in the family and if the adolescent seems severely depressed. Thus, the nutritionist does not feel obligated to stress weight reduction nor to prescribe a diet for every obese patient referred to her. However, when an adolescent appears to be well motivated and when there are no contraindications for weight loss, the nutritionist becomes a consistent contact for instruction and support.

Growth failure: Many adolescents who come to our clinic are concerned about their physical growth, particularly the short statured, the physically weak, or the sexually delayed male. The nutritionist contributes a great deal to the therapeutic program for

such patients, not only by helping them select the proper foods and by encouraging good eating habits, but also by treating them as responsible adults. Often parents and other adults tend to look upon the small adolescent as a child and to treat him as much younger than he is. When the nutritionist recognizes the boy's sensitivity about his short stature and treats him as an independent young adult, she helps to bolster his sagging ego. Wisely, she works with the adolescent boy alone and avoids direct involvement with his mother.

Mental retardation: About 20 percent of the referrals to our clinic are for mental retardation. The nutritionist has contributed much valuable information to our understanding of retarded adolescents by exploring their eating habits, their feeding skills, and the use of food in their families. We have been impressed with how often food, particularly high carbohydrate items such as candies, snacks, and desserts, is used as a reward or a bribe for good behavior. We have also found that parents tend to give their retarded child the kinds of food he likes best and are sometimes hesitant to introduce new items to his diet. As a result, the nutritional intake of retarded adolescents is often poor and lacking in important nutrients.

Because so many of the nutritional problems of retarded adolescents can be traced to the parents' tendency to infantilize them, the nutritionist concentrates on helping the parents encourage more independent behavior. She not only shows them how changes might be made in the adolescent's diet but, if the retarded adolescent is a girl, also encourages her participation in food preparation and other homemaking activities—areas of skill development that frequently have been neglected by mothers who underestimate the potential abilities of their retarded child.

Skin problems: Teenagers are very much concerned about their appearance. Acne, a source of much unhappiness, is a common problem which brings many adolescents to our clinic. The nutritionist helps reinforce the physician's therapeutic regimen through

dietary instruction and encouragement and by helping them choose proper foods. She is especially careful to take a positive approach when dealing with these young people, emphasizing the foods that are permissible rather than only those that are forbidden.

Some principles

In summary, the experience of our adolescent clinic indicates that a nutritionist can make an important professional contribution to the successful functioning of an interdisciplinary team when—

1. She is inventive and resourceful in her consultations and in making nutritional recommendations and is able to sell her ideas to other professional particularly the physician. (Many physicians have had little experience in working with nutritionists and tend to identify them with the hospital dietitian who functions in quite a different capacity.)

2. She is not afraid to make observations on aspects of the adolescent's behavior other than those related directly to nutrition.

3. She does not feel bound by tradition and is willing to try new approaches or methods in dealing with teenage patients.

4. She asserts herself as an independent member of the team, yet, at the same time, is able to work cooperatively with members of other disciplines.

5. She recognizes her limitations and, if she feels she cannot work effectively or comfortably with certain types of patients or age groups, reveals this to the staff and seeks other ways in which she can contribute.

6. She periodically evaluates her accomplishments to find ways to expand the scope of her activities and to broaden her understanding of the needs and behavior of adolescents.

Functioning in this way, the nutritionist can make a unique and significant contribution to the total care of the adolescent patient.

moving EMOTIONALLY DISTURBED CHILDREN

from institution to foster family

REGINA V. FINE

“Are you having a good discussion?” queried a bright, impulse-ridden 9-year-old boy, poking his head in the doorway for about the sixth time during an emergency session the social worker was having with his foster mother. Abandoned by his natural parents before he could remember, David had, as he expressed it, “messed up” several foster homes and spent 3 years in an institution before being placed in one of our special foster family homes for emotionally disturbed children. For the first time in his troubled life he had begun to trust adults and tentatively think of putting down roots. Then once again he had exploded with antisocial behavior, causing a crisis in the foster home. He was anxiously awaiting the verdict. Was he to be rejected again?

David's erratic behavior is typical of what the Family and Child Services, a voluntary agency in Washington, D.C., faces in its daily struggle to maintain severely traumatized children with specially selected and trained foster parents. Periodically, these patient, forbearing people seem to reach the limit of their endurance and then the agency must immediately respond to their call for help, bolster their egos, and encourage their efforts, so that with renewed vigor they can return to the task of helping the children who need them.

In August 1963, Family and Child Services, with

a small grant from a private trust fund, undertook the task of meeting a community need, that of developing special foster family homes to care for children with varying emotional disturbances and to contribute to their healthy growth and development. The program chiefly serves children who are ready to return to family living after being in a residential treatment center, but whose parents, due to their own unresolved problems, are not yet prepared to receive them or may never be able to do so. It also serves some children referred from psychiatric clinics as needing to get away from a damaging environment before their problems become so acute as to require their placement in a residential treatment center.

Thus far, we have placed 17 children with 13 foster families. Seven children have been in placement with us for 2 years or more, three for at least 1 year, and seven others for shorter periods. Our children have ranged in age from 5 to 13½ years at the time of placement. Eleven are boys and 6, girls; 6 Negro and 11 white. Their socioeconomic backgrounds range from lower income “culturally deprived” to upper middle class “culturally advantaged.” Thirteen children have come to us from five different institutions—a large public institution for dependent and neglected children and four small, voluntary residential treatment centers for emotionally disturbed children. The others have not been in residential treatment and, we hope, will not need to be.

Initially, we had planned to place only one emotionally disturbed child in a family. However, we have experimented with multiple placements in instances where the foster parents gave promise of being able to manage more than one sick child. This arrangement offers the advantages of lessening the

based on a paper presented at the 3d Annual Conference on Foster Care for Emotionally Disturbed Children, Merrill-Immer Institute of Human Development and Family Life, Detroit, Mich., Feb. 25–26, 1966.

sense of isolation for the new child being placed and stimulating the healthy development of the child already in the home. It also makes it possible for the social worker assigned to the program to concentrate on fewer homes while serving more children.

Preplacement planning

As we demonstrated our ability to secure the kinds of foster homes needed to meet the individual needs of disturbed children, we began to be asked by clinics and residential treatment centers to participate in multidiscipline staff conferences about children for whom foster family care was under consideration. Thus it has become possible to plan ahead for individual children, to look for a home, with a specific child in mind, to establish routines for exchange of information, and to work out more careful, satisfactory preplacement procedures. To avoid jurisdictional problems, our program has assumed responsibility for preplacement costs, such as payments to foster parents for weekend trial visits and transportation to and from the institution.

One day, we hope, movement of any child from one place to another, be it institution to foster home, own home to foster home, or changes in foster homes, will be done with as much careful planning as we in specialized programs are trying to manage today. A carefully prepared transition is, however, especially important for the child who is going back to the community from a treatment institution where he may have felt the only security he has known in his life. In our program, it often takes 3 or 4 months.

We had thought parents would be available to participate in preplacement planning, but none of our children have come from intact families. Most of them are extremely vulnerable to rejection, having experienced it many times in their short lives. Some have never known their natural parents and have only fragmented memories of early foster homes that

failed, often for reasons obscure to them, leaving scars not easily healed. Some come from homes broken by the father's desertion or imprisonment in which the mother has had a succession of paramours. Some have inadequate, disturbed parents who flit in and out of the picture making elaborate promises that they never fulfill. Some have brothers or sisters who have been kept at home, thus adding to their intense feelings of rejection and low self esteem.

One 10-year-old girl "laid it on the line" during her first interview with me, as the person who would find her a family. She said, "I'm ugly. I'm bad. I'm no good. I set fires." Her self-appraisal was based on the many unhappy experiences she had had in foster family living. If I was going to look for parents for her, she reasoned, I had better know the worst!

Transitional therapy

Preparing the child for foster family placement stirs up old traumas which may have lain dormant during the child's years in an institution. It means encouraging the child to give up the tenacious fantasy that one day his mother (or father) will set up an ideal home for him. In this period, the child needs the opportunity to express his feelings of anxiety, ambivalence, and fears of the unknown, as well as to reevaluate the past and the present more realistically so that he can participate in planning for the future. This can be a most productive period therapeutically for the child, for he may reveal conflicts the therapist that he had never revealed before.

We have learned that instead of waiting for the "old" therapist to taper off before the "new" one takes over, as is traditional in clinical practice, it is better to have the child begin to relate to the new therapist, the placement agency's caseworker—while he still clings to the therapist at the residential center. In this very difficult period of transition, the child can use more intensive exploration of his problems than can be managed in once-a-week contacts.

We have found that, at first, the child's conversations with the new therapist are limited to questions regarding the foster family, reports of weekend visits, complaints regarding restrictions, and the like. As the relationship with the new therapist deepens, some of the old doubts and worries, previously aired with the residential therapist, are brought in our sessions and the roles of the two therapists seem to become fused into one. This eases the child's transference from one therapist to another and cuts down

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on separation anxiety. Of course there needs to be a close working relationship between the therapists, a mutual trust of each other's competence, self-awareness of feelings derived from vested interests, and a constant exchange of information as to what is going on in the therapy sessions, in the residential environment, and in the foster home.

Learning from failure

Anyone who undertakes to move a child from residential treatment to a foster home, even one especially selected to meet the anticipated needs of the disturbed youngster, is taking a calculated risk, though the decision is made out of the best clinical judgment that the patient is ready for the move. Therefore, he must be prepared for failure, as well as success, recognizing that as much can be learned from one as from the other that can later be put to use in the service of other children. As one of our 12-year-olds sagely unlearned after a year in successful placement, "Everybody makes mistakes sometimes, only you gotta learn from them so they don't go to waste."

One of our early placements was John, a teenage boy who had spent almost half his life in institutions. The middle child of 11 children in a deprived, disorganized family, he had been sent to a large public institution for dependent and neglected children at age 7, after his mother was admitted to a mental hospital. When he was only 8 years old, he had attempted suicide by hanging. After observation in a psychiatric ward, he was placed in a residential treatment center. At the time he was referred to us, John was an attractive youngster whom a recent spurt in growth had changed from a small boy dubbed "Pee-wee" to a "big boy" tolerantly accepted on the fringes of the older adolescent group. He expressed eagerness to leave the institution to try life with a family.

In accordance with our preplacement procedure, the prospective foster parents visited the treatment center with the social worker, were briefed by the staff on the boy's background, present condition, and areas of possible friction, and met John, who conducted them on a tour of the buildings and grounds. They invited him to spend the weekend with them, and there followed several weekend visits before placement was finally effected. Arrangements were made for John to continue his weekly sessions with the institution's therapist during the first month in his new home, and for this to taper off as the new therapist took over and established a relationship with him. The foster parents were prepared to be

warm and accepting but at the same time to keep their distance, so as not to overwhelm him with their closeness.

All the built-in safeguards did not help. After one month John ran away—back to the residential treatment center. Why? Some unexpected and unfortunate events conspired to cause well-laid plans to go awry. One of John's buddies at the institution was found dead on the grounds. The staff and boys were upset, and the regular treatment appointments John was to have at the institution had to be canceled or deferred and John informed of the reason. Also, the close family relationships, the change from being an anonymous member of a group to suddenly having the spotlight turned on and being identified as an individual, had built up tremendous anxiety in this lad, who felt he had to keep a tight rein on his impulses to live up to his foster parents' expectations of him.

His first complaint to me during this period was: "Living in a family has more restrictions than being in an institution." Upon reflection, I had to agree with him. Parents feel responsible and like to keep track of a child's whereabouts. They show their interest by asking questions and including the foster child in their leisure-time activities. John had thought of family life as freedom to do as one pleased. Now he felt hemmed in by too much attention.

"Isn't it unusual for a child to reject the home?" the director of the treatment center asked me. I responded that John probably needed to reject the foster parents before they rejected him. But I was wrong. When I asked John about this at the center immediately after the runaway episode, he showed surprise and emphatically stated, "But they never would have rejected me." He had been quick to perceive that the strength of character and tenacity of purpose in these foster parents would have made them keep on trying to make the placement succeed. Therefore, the usual acting-out behavior would not have served to release him from what he regarded as an untenable situation; the only way out was to run. John could not tolerate the threat of close relationships and had to cling to the institution as his prime source of security.

What happens to the foster parents when the child in whom they have invested so much rejects them? Always a traumatic experience, such rejection can be especially shattering when this is the first child placed with them. John's foster parents were young, deeply religious people, who had had no children of their own. They did have a 7-year-old

adopted daughter and had looked forward to foster parenthood as a way of giving another child the same kind of devoted care that had nourished her.

The strong relationship that these people had established with the worker during the home study made it possible for them to use intensive casework support after John left. The worker shared their feelings of guilt, their sense of failure, the blow to self-pride. She reminded them that the placement had been a team effort based on the professional judgment of a multidiscipline treatment group who had known the boy for years. She pointed out the positive side of the experience—what had been learned about John that might be used to help him.

To express our confidence in the ability of this couple to be adequate foster parents for the right child, we immediately set about making plans to place another child with them, a younger boy, Joe, from a different treatment center. Joe presented an entirely different set of personality problems and really "put them through the wringer." But after 2 full years in their home he is exhibiting marked signs of healthy development.

Preplacement preparation

We have talked with all our children before placement about their prospective foster parents, the other children in the family, if any, the pets, the location of the home, and the like. We have answered their questions as fully as possible and relied on the preplacement weekend visits to round out what they needed to know. We have learned, however, that for some children, particularly those who have come from disintegrated homes, who have been in an overpopulated center for several years and from an early age, an educative process is necessary to prepare them for family living and for participating in the outside world. They need to be told not just about the good things to anticipate, but also about what will be expected of them. Such simple things as how to behave at the table and how to use knife and fork properly can be real stumbling blocks for an anxious child faced with making his way alone in a strange environment. The foster parents may understand his mistakes, but what will happen when he eats in the school lunchroom or at a birthday party? Once a child is singled out as different, becoming the butt of his peers' ridicule is almost inevitable, and children know this. One of our children invited out for Thanksgiving dinner ate only celery, the only thing he was sure he knew how.

In the family and the community, children develop defenses to cover their areas of vulnerability. But children who have never developed healthy defenses or whose defenses have broken down are encouraged when they get to a residential treatment center to talk about their traumatic experiences so that they can be helped to cope with their feelings. These children then need to be taught what most children learn quite early in a family setting: that there are some things that are personal and private and are not to be discussed outside the family circle. Other wise they may naively respond to friendly questioning in such a way that neighbors become apprehensive and warn their children against becoming too friendly with them.

One newly placed 10-year-old boy, when taunted by other boys, tried to excuse his strange, sometime infantile behavior with "But I've got problems. His feelings were hurt when they did not understand. However, he quickly learned not to suck his thumb in public and gave up hiding behind trees every time a group gathered. Perhaps he could have managed that sooner had he been fully aware that outside the institution odd behavior is not acceptable even on the basis of unresolved conflicts. The treatment center may have good clinical reasons for not interfering with symptoms, but if a child is to live in the community, he must be helped to know how.

Some children who have lived in an institution for a long time have become accustomed to having activities planned for them and have not developed inner resources for entertaining themselves. In the foster home, they are at a loss to know what to do with themselves "between times." Since many of these children have learning problems, reading is not a activity they turn to naturally. They also miss the stimulation of having other children around.

Early in placement, some of our children complained of not being allowed to watch their favorite television programs. Since the foster parents denied restricting them, we were puzzled. Then we learned that the institution they came from took responsibility for calling the children in when it was time to watch TV. How would foster parents know this? Also, what parent would feel a TV program was as important as to warrant interrupting a lively baseball game in which a child was happily participating? Going into a family from an institution meant adapting to a whole new schedule of daily living.

As a child prepares to leave the institution for the foster home, he almost invariably develops separation anxiety. After several happy weekends, just as we

begin to feel he is apparently going to make the transition smoothly, he may suddenly refuse to go for his weekend visit. He may say he hates the foster family, list many complaints, and even react violently if attempts are made to force him to go. At the bottom of this behavior is the reawakened deep fear of separation from the familiar, often expressed with tears, "If I leave, I can't come back." At this time he needs to be assured that he no longer needs to be isolated from the community, that the residence's staff members will not forget him, and that at some point he can return to visit.

Maintenance in placement

Similarly, there comes a time when the "honeymoon period" with his foster family is over. The child seems terribly unhappy, rejects the foster parents, and says he is sorry he ever left the institution. It is important then to consider whether it is now time for a return visit to the residential center. The decision has to be made on an individual basis, depending on an understanding of the emotional factors in the child's depression.

We do know that children tend to build up fantasies that glorify the institution and their ties with its staff. Going back helps to bring the institution into better perspective. If properly timed and carefully planned, a return visit can be extremely beneficial for the child. He can be helped to face the fact that nothing ever remains the same. There are staff changes, old playmates have gone and new children have taken their place, the walls of his old room may even have a fresh coat of paint. Though he may be a little dismayed at first, the child usually gets the message that he must move on and continue to grow.

Our foster parents are especially recruited to work with emotionally disturbed children and are paid \$150 per month for their services and the child's board, a rate higher than the usual rates for foster care. An intensive home study over a period of about 3 months includes interviews with each member of the family, together and separately, and explores their motivation for offering foster care, marital and family balance, sensitivity, ability to cope with anxiety and handle crises, and flexibility. Out of the first 32 couples who applied, only 2 met our qualifications.

Our foster parents are unusual people, with great interest in providing a suitable environment for troubled children, willing to invest of themselves, to take direction from the agency, and to participate

as "team" members in working toward our goals. We have attempted to increase their knowledge of normal and deviant child behavior, to help them avoid problem situations, and to support and sustain them through the inevitable crises that arise. We see the foster parents and children in weekly individual and sometimes family sessions, either in our offices or at their homes. We have tried to do a careful job of "matching" children and foster parents through awareness of the vulnerable areas of each.

To maintain a disturbed child in placement, the caseworker must quickly establish a close relationship with the child, as well as the foster parents. Thus he can keep aware of the emotional climate in the home and sometimes nip a crisis in the bud.

For example, one of our foster mothers became pregnant for the first time after 12 years of marriage. She and her husband had adopted a little girl and also taken in two of our boys for foster care. One boy had been with them for more than a year and had progressed well. The other, recently placed, was still having difficulty finding his "sea legs." Shortly after we were advised of the mother's pregnancy and before the children had been told, the "new boy" confided that he had a "problem." The little girl had told him that "Mama had changed her mind and in 9 months she would send him back to the institution." He thought she had overheard this. Quickly, but diplomatically, the matter was discussed with the foster parents who, although they had never even considered giving up the children, had been emotionally preoccupied and oblivious of the effect this was having on three very perceptive and anxious children. The fact that there was a relationship between the caseworker and the most disturbed child helped prevent what might have become a critical situation.

The natural parents

The group of children we have placed so far have had parents who for various reasons were either completely out of contact with the child or unavailable for any casework services. Our attempts at forming some relationship with the few parents and one set of grandparents who have expressed interest in their children have been time consuming and fruitless as far as hope for effecting any real change in their attitudes or ability to provide a fairly stable home. The most we have accomplished is the establishment of some controls to limit the damaging effect distraught parents can have on their children and to prevent their interfering with therapeutic plans. In one

case, we reluctantly had to release a severely disturbed child to a highly disturbed mother, although he had made remarkable progress in his foster home, because the mother created constant and violent disturbance in the foster home.

We can, however, report success in enabling another mother, first, to tolerate the controls necessary for preventing her unconsciously destructive influence on her child, and, second, to accept the kind of help she personally required but had never been able to admit was necessary.

Tom, a handsome 8-year-old boy, was referred to our program by a 5-day treatment center, because all attempts at therapeutic intervention were being thwarted by his weekends at home with his widowed mother. Confined to a wheelchair because of a leg amputation, she had been able to care for Tom as a baby, but as he grew older she was unable to impose the restrictions necessary to help an active, alert boy develop properly. She babied and overindulged him and encouraged a seductive relationship between them that kept the boy so overstimulated that he had little control over his impulses.

The mother denied having any problem with Tom until he became so completely unmanageable he kicked her leg and set fire to her mattress. Tom was then referred to a psychiatric clinic, but when it became apparent that psychotherapy could not help him so long as he remained with his mother, he was placed in a residential treatment center.

Though mother and child had been known to our agency since Tom was about 3, the mother had never been able to admit her need for assistance other than with practical matters. By viewing the problem as the child's only, she avoided personal involvement in a therapeutic relationship. However, when she was forced to face the need for permitting her son to be placed in a "full-time foster home," she was able to consider her own need for help.

The big problem for Tom's mother was the fact that she had so few sources of emotional satisfaction. As an attractive, intelligent girl of 19, she had been a registered nurse working in a hospital's nursery for newborns. Then she had lost a leg in an accident and so her hope of professional achievement. Years of rehabilitative efforts had made her completely self-dependent in regard to her own personal needs and able to manage her household efficiently without outside help. But Tom had given purpose and direction to her life; with him away, the days were long and empty. One day as she discussed her frustration with her caseworker, she referred to how useful she

had felt when Tom was an infant and she had been able to meet all his needs. She felt she could do the same for other babies. She had heard that our agency was in urgent need of foster mothers for infants awaiting adoption. Would we consider her?

After much consultation between the agency's departments, we came to an affirmative decision. A 3-week-old, premature baby was placed with her, and in the ensuing 8 months we were able to observe what expert, tender loving care can do for an infant who has had a poor start in life.

What has this done for Tom's mother and for Tom? As the mother began to feel productive, her feeling of self-worth increased, depression came less frequently and soon disappeared altogether, her attempts to sabotage our work with Tom became rare, her hostile attitude toward his foster parents gradually changed, and the change was conveyed to Tom so that he felt freer to become closer to them. She became actively able to support our treatment goals and to allow Tom to separate from her and to take steps toward maturation. She gave clear evidence that she had emancipated Tom in her Christmas cards, which previously had been signed "Tom and Mary Jones," as though they were husband and wife but were now signed "Mary Jones and Tom." She also began to spend money on herself instead of showering everything on Tom as she used to do.

Tom has had some difficulty in adjusting to his mother's involvement with another child, but we have been able to help him work out some of his feeling in therapy sessions. His hyperactivity has markedly decreased. His attention span has increased so that he is able to finish his work and achieve at grade level in school. His aggressive attacks on younger children, which threatened to result in expulsion from school last year, seem to be ended.

In conclusion

In this paper I have attempted to delineate some of the most frequent problems encountered in helping an emotionally disturbed child move from the protected environment of an institution to the world outside and have offered some suggestions as to how these might be handled. I shall end with a plea for creative exploration of new ways of helping such children. Within even a small, somewhat traditional type of foster-care program, there is much room for flexibility and experimentation, if one is willing to invest the time and effort necessary and is brave enough to take a calculated risk.

keeping EMOTIONALLY DISTURBED foster CHILDREN in school

WALTER J. AMBINDER ● LOUIS H. FALIK

● A basic assumption of foster-home placement is that the child being placed has some ability to live in and profit from a family environment and to maintain satisfactory relationships with the community of which the foster family is a part. The foster child's inability to get along outside the home—in the neighborhood or in the school—is often a major reason for the breakdown of the placement. Foster-care caseworkers have concentrated for the most part on supporting the home because their caseloads are so large they do not have time to guide untrained foster parents in working with such agencies as the school. Other than recognizing that the foster child often has difficulty in school, they are unable to pay sufficient attention to problems of adjustment outside the foster home. They are often in the uncomfortable position of sensing the potential stress that could destroy a good home placement without having the resources to prevent a crisis.

In short, although we know that a child's failure to adjust to school can overtax even the most stable placement and the most skillful foster parents, the methodology of effective intervention is uncertain. Because of this uncertainty, the work of school and agency to help a disturbed child is often difficult—yet it can know some success. The work of the Detroit Foster Homes Project with one boy, whose story this article will recount, is a case in point.

The staff of the 5-year-old Detroit Foster Homes Project realized the need to carefully evaluate the adjustment of foster children to school from the many case histories of emotionally disturbed children they

studied before selecting the 14 boys with which they are now working. Sponsored by the Merrill-Palmer Institute of Human Development and Family Life with a grant from the National Institute of Mental Health (5R11-MH-01551-04), the project is demonstrating that children who have lived in many foster homes, who have been subjected to marked family disorganization, and whose conduct reflects emotional disturbance, can be placed and kept in highly reinforced foster homes.

For most children, school is a difficult lesson in reality testing, for in school they must prove their worth on their own. The foster child must react to the cognitive and social demands of the school without the love, security, and support most children get from their homes. His experience with many breakdowns in home environment can bring emotional instability and feelings of rejection and worthlessness. The case histories of the children selected for the project, all of whom had failed in several home placements, include many examples of difficulties in school, both academic and social.

These considerations have made us focus our attention on the adjustment of the foster child to school as a major aspect of his adjustment to life. In our school activities we follow two methods, one based on service, the other on research. The service method centers on school adjustment and the specific needs of the child, to provide effective supports for his day-to-day functioning. It includes contact with the school, clarification of the role of the foster parents in relation to those of school officials, direct

service to classroom teachers, and supplementary diagnosis and tutoring.¹ The research method involves the gathering of data on the adjustment of the child to school and includes basic data on which to determine the effectiveness of the project's efforts.

Our school intervention methods have meaning for child welfare practice everywhere, we believe. The most obvious meaning is that children who are as emotionally disturbed as those we work with cannot be kept in school, much less in foster homes, without special attention. It is our experience that many of the children who fail in a placement might have succeeded if attention had been given to their adjustment to school. Foster-care agencies must continue to seek effective ways of working with the school. Sometimes, this only means having a staff member who knows what causes concern to teachers, understands the social structure of the school, and has the ability to bring about change.

It is also our experience that if the agency can work effectively with the school, the child's prospect for a successful adjustment to the foster-home placement will be greatly improved. Most foster parents need the satisfaction of having the foster child succeed in school; if they are denied this gratification or are subjected to pressure from the school, they may reject the child. Several of our caseworkers have felt that the project's efforts to keep the child in school were the cohesive force that held the placement together.

At the time we placed the 14 boys the project has worked with in foster homes, we expected school adjustment to be difficult for them. Eight had already failed one or more grades. Although they were older than their classmates, all were at least 1 year below their grades in reading; four were 2 years below; and several were classed as nonreaders. On the basis of individual intelligence tests, none could be called mentally retarded, although the

school considered several as retarded because of their poor performance on school paper-and-pencil intelligence tests and in class. In general, their cognitive functioning was similar to that usually associated with cultural deprivation, and it frequently suggested emotional problems. Nearly all had histories of poor social adjustment in school, exemplified by conduct ranging from fighting and destructive behavior to severe withdrawal, lack of participation and extreme immaturity.

The case of Harold

The history of one of our boys, Harold, which follows, illustrates the extent and complexity of the project's involvement with the school and describes the evolution of our plan for intervention. His case was chosen because it highlights many of the critical issues we face, and it can serve as a basis for discussion of the general problems and prospects.

Harold is perhaps the most disturbed child we have had in placement. He is a small Negro boy who has never had a home of his own. His mother was unmarried when he was born, and all his relations have rejected him. He has lived in several foster homes. About a year before being taken into the project, he was removed from a foster home in which he had lived for 5 years because the foster care agency found that the home had become inadequate. He had great difficulty in adjusting to the new home, and his conduct was characterized by temper tantrums, aggression toward other children and disorganized and uncontrolled behavior. He was highly distrustful of people and unable to tolerate close personal relationships. So uncontrollable was his behavior that, in a short time, at the age of 7, he was admitted to an inpatient psychiatric hospital for study and treatment; 4 months later the project placed him in a new foster home.

After Harold had spent several comfortable days in his new home, we entered him in public school. The project caseworker went with Harold and his foster mother to the school and held a conference with the two teachers who were to have him for most of the school day. She told the teachers that Harold had been in psychiatric treatment and that his doctors felt that he could now function in a normal setting, gave them some facts about his academic and social deficiencies, and suggested ways of handling him. The principal was not included in the conference. Both teachers seemed sympathetic and understanding, and Harold was accepted on the first

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day with apparent smoothness. The day after, however, the principal called the project caseworker to say that Harold's teachers were unable to control him. He was surprised to learn Harold's history and was defensive about having to cope with such a child "without warning." Because he had not attended the conference, he felt unable to intervene effectively.

The effect of Harold's behavior on the teachers pointed up to us that merely sharing information and offering help were not sufficient. The teachers had "not heard" what the caseworker said.

The first days at school were overwhelming for Harold. At first, his behavior was confused; later it became disorganized, aggressive, and uncontrollable. When he slapped a teacher, two project staff members had to take him away. The principal felt that the school could not keep him unless he showed immediate and major changes in behavior. He had been in school only 3 days.

What modifications in Harold's behavior were possible, we asked ourselves. Apparently, the school had not been adequately prepared for his kind of behavior, and we had overestimated his ability to cope with the routine of the school day. Having come from a hospital's protective environment, where lessons were brief and the classroom confined, possibly the longer school day, the physical complexity of the school building, and the personal relationships the school imposed had overwhelmed him. With this in mind, we thought it important to determine how much information the school could effectively use and what kinds of supports we should offer. Consequently, we transferred him to another school near his home after we had conferred several times with the principal over Harold's history and school adjustment problems as part of a formal plan for his attendance. The principal agreed to place Harold with a teacher especially good with difficult boys, and to let Harold attend half-day sessions only.

The teacher was indeed skillful in handling him. Not threatened by his aggressive outbursts, she allowed him a good deal of physical freedom and continually assured him that she liked him and that he belonged in her room. She soon understood the conditions which set off his aggression and how to avoid them. The amount and intensity of his disturbed behavior began to subside. He was still difficult to handle, but he seemed to have reached a level of adjustment which both he and his teacher could tolerate. Toward the end of the semester Harold's stay in school was extended to a full day.

At the end of the semester, because of Harold's great academic deficiency and the special relationship between him and his teacher, the teacher felt she should keep him for another semester. We agreed. After the summer vacation, Harold returned to her class and continued to improve. He seemed to make friends, to work with others in the classroom, and to be almost able to conform to rules.

We had many questions, nevertheless, regarding the permanency of these changes. The sheltered relationship with the teacher and the other supports the program provided could not be maintained indefinitely. At the end of Harold's second semester with her, the teacher suggested that because of his age and size he should be moved on. The change, of course, brought a new teacher and a new environment. Because the project staff felt that Harold's adjustment was still far from adequate, we arranged for his old teacher to work with him as a tutor to provide a continual relationship through the next semester's changes. This plan was critically timed, as the new semester brought great stress to Harold.

The first new teacher we placed him with decided after 2 weeks that she could not control him. We then placed him with a teacher who, though highly experienced and competent, was rigid, aloof, and unwilling to admit that Harold had special problems. Nevertheless, he seemed to make an adequate adjustment and responded positively to increased controls.

Problems in the school

Harold's maintaining ties with the former teacher while working with the new one strained the social order of the school. The two teachers were soon competing with one another. The principal knew of their struggle but did not think he should intervene because he considered both teachers as competent, articulate, and strongly committed to making progress with the boy.

Although Harold was apparently responding positively to the increased controls of the new classroom, his reactions suggested emotional strain. Acting out became less pronounced, but he showed tension in other ways. He fainted in class and began to truant and to disappear within the school building. His aggressive outbursts were severe. In our judgment, the situation was becoming too difficult for him and our resources for keeping him in that school were being dissipated rapidly. We had to consider another change of schools.

All this time, the project had kept in touch with

the principal of the first school in which Harold was placed, who was following the case with interest. He now felt that he could provide a class with more flexibility and support than the second school and that there would be more possibility than before of bringing special help to the school and of involving the school and the project more closely. He assured us that he could place Harold with an especially skillful teacher, an assurance the second school could no longer give.

At the project, we had come to believe that the principle of stability in school placement was, in some instances, secondary to getting a child off a "hot seat." Although the second school was committed to succeed with Harold, it appeared to us that the attitude of its staff was frozen and its emotional climate was such that the teachers would have difficulty in seeing changes in Harold. There were arguments against changing schools, of course, such as the effect of frequent school changes on a foster child, the feeling of failure a change might bring to Harold, and the advantage of familiarity that three consecutive semesters in one school building had brought him.

We made the change, however, but the trend toward deterioration continued in spite of many contacts with specialists, flexible and sympathetic administrators and teachers, and attempts to structure his experience. Harold's aggressive and disorderly behavior increased in intensity and frequency. It became clear to us that a public school probably could not help a child with his needs.

At this point, we questioned Harold's suitability for foster-home placement and considered sending him into residential care. As a last move, however, we placed him in a private school with small classes and special programs for disturbed children. At first, Harold's behavior did not change. He could only attend school an hour a day.

A fortunate observation by the caseworker, however, brought a change for the better. She noticed that Harold's foster mother had a remarkably calming effect on Harold. At our request, the mother came to class with Harold and remained in the room while he was there. After several weeks, when he seemed better, she did not come to the classroom but remained in the building with Harold's knowledge. A little later, when he seemed even better, she remained at home on call, also with Harold's knowledge. As the semester passed, Harold's periods of control gradually lengthened, and we could slowly withdraw the massive support we had been giving him. He was able to concentrate on schoolwork for brief periods,

began to show signs of learning, could attend school for a full day and ride the bus back and forth.

Recently we added an academic tutor, and some progress is being made on lessening his great academic deficiency. Although he still has behavioral difficulties and is far from ready for public school, the staffs of both the private school and the project believe he has made marked progress.

Working with the school

Harold's case, as we have said, highlights several basic issues in dealing with the school in behalf of emotionally disturbed foster children.

The most obvious issue is the necessity for shaping the school experience to fit the child's behavioral needs and capacities. With Harold, this went beyond what the public school or even the private school could spontaneously offer. Yet much was done within the public school. Our experience with Harold brought up questions regarding the timing of initial contacts, the extent of involvement of the foster parents, the role of the caseworker with the child and parents, and the role of the referring agency.

The problem of offering the school information about behavior that could be expected was crucial in the case of Harold, as with most emotionally disturbed children. An agency cannot assume that information relayed once is heard and understood completely. Rather, it should give information like a clinician—a little at a time as the client reacts. An estimate of the school's ability to benefit from a consultative relationship must be made and the operational usefulness of the consultation determined. The degree that caseworkers can describe the child's functioning in terms meaningful to educators and outline problems and behavior the teacher is likely to face, preparation and flexibility will be easier.

Although it is important to provide continuity and individual help for the child, in Harold's case, because of his great emotional disability, our help created strain that hampered the school's ability to deal flexibly with his behavior.

The role of the tutor needs to be emphasized whether he is a member of the school's staff (as in Harold's case) or a teacher from outside. The tutor's knowledge of the educational and emotional needs of the foster child, his ability to deal with the "building atmosphere" of a school, and his ability to explain the child's problems to the teachers keep understanding flowing between the school and the agency. His work also helps keep the agency abreast of planning,

and aware of problems, even before they come into the open. With Harold, as with all other emotionally disturbed children, day-to-day life in school is tenuous. It is important to keep the channels of communication open, even against obvious resistance, to prevent a crisis or to lessen its force.

Another aspect of Harold's case, also present in the experience of most of our foster children, deserves attention. During the time Harold's school behavior was so turbulent, the project tried to stabilize and solidify the foster-home placement. The foster child has to make adjustments on several fronts at once, and sometimes demands for academic and social progress in school must be delayed until the child can establish a foundation of trust and security at home.

Casework intervention with Harold was designed to support him in his school attendance by meeting with him to talk about his problems, helping him develop other behavior patterns, and so on. At the same time, the caseworker worked with parents to interpret to them what was happening in school and to deal with the crises of daily living—to help Harold become acclimated to his foster home and to help his foster parents become used to his behavior and develop comfortable methods of coping with it.

Because many foster parents, lacking experience with the school, approach teachers and administrators with anxiety, the caseworker must often help foster parents understand the child's school problems. Conversely, the agency often does not know what strength the parents have for helping a child adjust to school. Harold's caseworker felt that if his foster mother had been more actively involved long before she was, Harold might have made greater advancement and have had fewer setbacks. An agency, therefore, must weigh the foster parents' desire for involvement with the school, their familiarity with the school, and the nature of the child's expected behavior to determine the kind and extent of foster parent involvement.

Some conclusions

The course of our involvement with school officials and the educational problems of the project foster children necessitate continual evaluation and planning. We are constantly retracing our steps and having to rise to crises. Although there are few guidelines for effective intervention in a child's school experience, we have been guided by several considerations: first, the need to insure the foster-home placement by insuring the child's school adjustment; sec-

ond, the need to gather data concerning the problems and difficulties emotionally disturbed children meet in school and to determine what methods could be developed that would make adjustment easiest. These general considerations were evolved into specific issues by our advance planning and by the problems of keeping 14 foster children in school.

Harold's case material highlights these considerations and a few of the specific issues. We have not presented hard data because we wanted to emphasize the character of our involvement and of the personal interaction between agency and school. The problems arising from Harold's school attendance—such as his failure to learn to read at grade level and his fighting in class—have brought into focus the fact that such problems, how they are handled, and the effect they have on the foster child, the foster family, and the school can and often do influence the whole foster-home placement.

From our work with the schools, we have evolved several methods of working toward school adjustment. We have found that it is often useful to start contacts with administrators, rather than with teachers, before the child enters school to set the stage for contacts with teachers, to provide insight into the amount of cooperation available, and to keep channels open should "system-level" changes be considered. After conferences with the child's prospective principal and teachers, careful decisions concerning the sharing of information, further action, and the like must be made. We have found also that the importance of describing the child in school-related, operational terms and gaging the level of interpretation needed about his problems cannot be overemphasized.

From the standpoint of child management, we have found it essential to involve the foster parents as fully as possible in the child's school environment. In addition, the caseworker must often work closely with the foster parents around school problems.

We have also found it important to determine the kinds of special help the child can make use of and to plan with the child, the foster parents, and the school to provide such help. Occasionally, such planning will become the source of some conflict within the school "life space" of the child, but as the case material suggests, this can and must be worked out. The indirect benefits of such supports can be critical and can occasionally serve to sustain all participants through a crisis.

¹ Shiefman, Emma: A schoolteacher in a child welfare agency. *Children*, May-June 1966.

how to alleviate the first-year shock of . . .

teaching EMOTIONALLY DISTURBED CHILDREN

SHIRLEY COHEN

● Among the results of the Elementary and Secondary Education Act of 1965, with its encouragement of innovations to bring educational opportunities to "educationally deprived children,"¹ is a widespread interest in establishing special classes for emotionally disturbed children. In some States this interest has been augmented by State legislation, as in New York State where the establishment of such classes is now mandatory. Though under a 1963 act² some Federal money has been made available to States for training teachers to conduct such classes, a great many schoolteachers with little or no special training will undoubtedly find themselves faced with classes for disturbed children in the near future.

While thousands of books, pamphlets, manuals, and articles are aimed at guiding the new teacher of a regular class, few shed light on the difficult task facing the experienced teacher who is working with a class of emotionally disturbed children for the first time. Therefore, it seems appropriate to describe some principles for approaching this task. Those that follow are derived from my own experience in just such a situation and from my subsequent work supervising other teachers in their first year of teaching classes for emotionally disturbed children.

The first year with emotionally disturbed children is often a year of crisis for the teacher—a year in which a teacher's beliefs, premises, values, and expectations are shaken. The approaches the teacher

has come to have faith in do not bring the expected results, and the usually reliable methods for making things work better—more preparation and planning—prove not so reliable.

Whether a teacher's relationship to her class, her skill as a teacher, and her maturity as a person grow or wither depend on how she responds to the crisis of finding her "reliable" methods no longer working. She can respond to the shock of this new experience either by becoming more distant and more rigid, or by opening herself up to a kind of "culture" and a way of communication that are new to her, painful as this may be. Some persons who turn out to be the best teachers of classes for emotionally disturbed children have the most difficult time the first year. They are, so to speak, "shook up" the most, but the experience makes them more receptive to new ways of looking at events, new understanding, and new approaches. Take, for example, the following incident.

One day a teacher in her first month of working with a special class of emotionally disturbed children put on a record by the Beatles, got out some colored chalk, and encouraged the children to draw on the chalkboard to the music. Having taught for several years in regular classes, this teacher had a rationale for what she was doing. She felt that most of these disturbed children were too inhibited and needed more opportunities for free and creative activities. She had used this kind of activity successfully with classes of young children before.

For the first 10 minutes the result was beautiful. The children were interested and involved. They were communicating with one another and working cooperatively. The chalkboard was brilliant with color and design. But then the quality and tenor of the experience began to change. The children became wilder, less creative, and more destructive. The beauty of the cooperative production disappeared under a barrage of uncontrolled actions. The floor and the children themselves were covered with colored chalk. Some of the children became highly anxious.

Based on a paper presented at the First Conference of New York State Educators of the Emotionally Disturbed held in Hawthorne, N.Y., May 1966.

When I described this incident to a group of teachers of disturbed children, each one was quick to point out the teacher's obvious errors: she had used the wrong music, at the wrong time of day, without having established clear aims and limits. These criticisms had some validity.

Yet the experience turned out to be a good one for most of the children. The next day I watched the teacher talk to the children about what had happened, and it was obvious from their faces and their voices that something good was happening to them. For the first time in the lives of many of them a disaster in which they had participated was not being blamed on them. The adult did not turn against them; on the contrary, she was taking a share of the blame for what had happened. She said to them: "I didn't plan that very well, did I? Next time we'll have to plan more carefully."

This woman will most likely turn out to be an excellent teacher for disturbed children.

Some principles

The following are the principles that, I believe, if followed, could alleviate the shock of the first year with such children if understood by the teacher.

1. *The teacher will do much better if she understands that what disturbed children need is someone who can be stable and orderly in the midst of their disorder.*

When I first considered teaching seriously disturbed children, I was advised against it by another teacher on the grounds that such children need a teacher who can regress with them. Time and experience have led me to a different viewpoint. What these children need is not someone who can regress with them, but someone who can live with, accept, understand, and see the need for their regressions, without becoming threatened or disrupted by them herself. The teacher who is cut off from her own feelings may not be able to understand and communicate with such children, but the teacher who is herself chaotic will not be able to serve as a model of health and strength for emotionally ill children.

On the physical level, for example, the idea that the teacher, rather than the children, has to be orderly means that for a long time the teacher may have to be the one who takes major responsibility for "setting up" and "cleaning up." Cleaning up is often a center of conflict between teachers and disturbed children. Here teachers fall back upon the old ex-

pectation that if children are properly warned of the approach of clean-up time they will or should clean up. If these children could get ready and clean up when, and simply because, the teacher told them to, they would probably not be in a special class. Being willing to clean up implies a set of attitudes and a degree of strength that do not exist, or exist only in rudimentary form, in many disturbed children.

2. *The teacher of disturbed children will do much better if she comes to expect the unexpected.*

The teacher who is working with disturbed children for the first time, in a sense, is moving into a new "culture"—the language is different, the way of perceiving the environment is different, and the rules are different. It takes time to understand how the class differs from a group of normal children as well as to understand the idiosyncratic ways each child has of perceiving and relating to the world. Of course, it takes more than just time to understand disturbed children. Training and sensitivity are crucial. And some severely disturbed children will leave even the best teacher puzzled.

3. *The teacher will do better if she expects and accepts little progress in some of the children for the first few months.*

It takes many disturbed children months before they are willing to conclude that the teacher is really for them, that they can really trust her, that she will not turn against them when the going gets rough. Until they reach this point, they may not be able to really get to the learning task that is the purpose of their being at school.³ They may not be willing or able to expose what they do not know or what they want to know. They may not be able to accept the position of one who knows less in relation to the teacher as one who knows more.

The teacher will also do better if she learns to

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recognize other kinds of growth besides academic achievement. If a child who was a habitual truant now comes to school regularly, growth has taken place. If a child who in the past rarely finished anything, or immediately destroyed anything he did finish, is now able to accept some of his work and allow the results to exist, growth has taken place. If a child who used to respond to teaching efforts with braggadocio is now willing to expose what he does not know or cannot do and to ask for help, growth has taken place.

Time takes on a different meaning when one works with disturbed children. Something that a regular class may adapt to immediately may take a class of disturbed children weeks to accept. Here is where just the right amount of "flexibility" in the teacher counts. Some teachers rigidly cling to practices carried over from regular classes in spite of overwhelming evidence that these practices are not appropriate for the disturbed children now in their charge. On the other hand, some teachers, finding that nothing they try works immediately, shift about so much that the children cannot tell what is expected of them or what to expect.

4. *The teacher will do better if she learns to attend to and understand nonverbal communication, her own as well as the children's.*

Only a small fraction of what disturbed children feel or think is communicated through words.⁴ The teacher has to learn to read gestures, facial expressions, body movements, and actions. Doing so will help her not only to understand the children but also to anticipate their reactions. Anticipation is essential in working with disturbed children. The teacher also has to become sensitive to her own nonverbal messages because most disturbed children learn to "read" them very well.⁵

In the following two examples, the teacher failed because of insensitivity to what the child was asking and how she was answering him.

Robert was a seriously disturbed boy who had been discharged from regular class in the first grade and was now in a special class. One day early in the term he came up to the teacher, removed a bandage from his right hand, and told her that his hand hurt. The teacher looked at the hand and replied: "That cut looks almost healed to me. Besides, the nurse isn't in today, and there's really nothing I can do for it." Then she turned back to her desk. Within 5 minutes Robert had attacked three children and disrupted the entire class.

This teacher had answered Robert's words in a rational manner, but in response to his message—"I need some support; I need to know that you care

about how I feel?"—her response, unfortunately, was negative.

Billy, another very disturbed child, had just returned to school, after having been excluded for 2 years in which he received intensive therapy and home instruction. The teacher was going around the room asking each pupil his name. When she came to Billy, he announced himself as Martin Luther King. The teacher became very angry and accused the boy of insolence and disrespect.⁶

This teacher felt threatened, and in defending herself forgot about the child. She might better have said: "Martin Luther King is a good person to want to be like," or "Martin Luther King is a man of peace so I expect you to contribute to the peace in this classroom."

Thus she would have been telling Billy and the rest of the class that she was not being taken in, but that she recognized that he may have felt like nothing and nobody that day; that his response was a defense against his own feelings; and that she was not going to try to rip it away.

Awareness of nonverbal communication is also important for achieving *congruence* between words and actions and between methods and aims, an aspect of teacher consistency not often enough recognized.

5. *The teacher will do better if she reexamines everything she does in the classroom in the light of the questions: Is this really worthwhile? Is it really a good way to achieve what I intend?*

Probably most teachers who go about such a reexamination seriously will find that much of what they have been doing does not pass this test. Recently I watched a teacher who had had the same class of disturbed children for almost 2 years spend a half-hour on the attendance, the calendar, the weather, the daily "story," the patriotic song, and the seasonal poem, all standard procedures in the primary grades of many schools. During the process the children became more and more restless, bored and cut off from the teacher. Afterward I asked the teacher what she expected to achieve by "doing the weather" every morning. She replied that she "did the weather" (with the pictures of a cloud, an umbrella, the sun, and a snowman) to make the children aware of the weather and of weather changes.

Why had this teacher not considered that if, after nearly 2 years, this daily procedure had not achieved the goal of making children aware of weather changes, either it was an inappropriate method or her goal was inappropriate? If the goal had been achieved, why was she "beating a dead horse"? The

elimination of such wasteful procedures will help eliminate some of the restlessness or apathy so often exhibited by disturbed children at school.

The teacher also needs to reexamine every aspect of classroom management, including selection and arrangement of furniture, use of bulletin boards, selection and storage of supplies, arrangement of activity centers. Which materials are kept in closed closets and which are left on open shelves? Where should the child who runs away be seated? Are "current events" only what one reads about in the newspaper, or do stories about events current in the lives of the children themselves also belong in this category and rate space on the bulletin board? Such questions are important in relation not only to classroom management but also to communicating the philosophy of this class to the children.⁷

Seeing individual needs

The crux of what a new teacher has to learn is to see not only the goals which she wants children to reach, but also how well all the parts of a child's personality—attitudes, controls, and areas of strength and skill—must be functioning before these goals can be reached. She has to learn how to help malfunctioning children negotiate the quarter steps toward these goals, small achievements which most other children do not need to work at consciously.

For this type of planning, preparation of the standard type—based on curriculum guides, reference books, charts, and the like—is not enough. Hand in hand with it must go another kind of planning, based on knowledge about disturbed children in general and about each specific child in the class. This kind of planning cannot be done by the teacher alone. It requires the insight of persons well versed in the recent developments in psychology, neurology, sociology, psychiatry, and education; in other words, a team of persons from different professional disciplines working together.

Such planning is concerned not only with the standard questions about reading, writing, and arithmetic, but also with such questions as: When should the teacher keep out of something and when should she move in to confront the child with reality? What should she do about such group reactions as scapegoating? How much protection can she give a child without fostering unhealthy dependency? How can he tell when she is becoming overinvolved with a child and perhaps repeating an unhealthy parental pattern? How can she know when withdrawal signi-

fies a marshalling of resources when it is serving no healthy purpose? What avenues of expression are to be made available to a particular child and what ones are to be avoided? How much weight is to be given to general school standards and expectations in defining special class activities and procedures? How can a child be prepared for return to a regular class?

Behind the labels "emotionally disturbed children" or "maladjusted children" are children having widely varying symptoms, degrees of pathology, and etiology of pathology. Some are aggressive, destructive, and delinquent; others are self-destructive, picking at their skin, banging their heads, biting their hands. Some are far behind in academic achievement; others are academically advanced. Some are constantly fearful; others show an abnormal lack of fear. Some are hyperactive and impulsive; others are lethargic and withdrawn. Some are caught up in complex fantasies; others are extremely concrete. Some are only mildly troubled; others, deeply so. Some are responding to the stress of acute situations in their lives; others have shown abnormal behavior since birth and are extremely disoriented.

Thus, in working with a class of disturbed children, the teacher cannot address herself to "the group." She must study, plan for, and relate to each child as an individual. It is here that she needs the help of the mental health specialists—psychiatrists, psychologists, social workers—who work in or with the school.

Teams, of course, will vary according to the type of personnel available. For example, in one school I know of a team, which consists of three teachers assigned to special classes, a psychiatrist, and a school guidance counselor, meets regularly once a week. Additional school or outside agency personnel, including social workers and psychologists, are asked to attend the team conferences when their special skills are particularly needed. The guidance counselor also meets separately with each teacher weekly.

In this school, a few weeks after the beginning of a term, a team meeting was focused on planning for a 7-year-old boy, David. Even among his peers in the special class David's behavior appeared bizarre. He never said a word to anybody about anything going on in the class, but occasionally he would come out with a phrase which seemed to make little or no sense. Anxious about how to deal with him, his teacher described his behavior to the others at the conference. The psychiatrist who had been seeing David individually told about some of the factors in David's background which seemed to have a bearing on his behavior, and then the team members considered together how to help David in the classroom.

Since childhood David had been cared for by his father, a seriously disturbed person who regarded himself as a poet. He

only attended to David when the boy said something "poetic"—something unrelated to everyday needs and expressions. Then, the father, who himself often spoke "poetically," wrote David's words down and showed him much affection. The father was now no longer in the home and David's mother had become very much worried about David's verbal behavior.

The psychiatrist explained that David's strange way of speaking was probably a normal reaction to his past environment. The team decided that the teacher should relate to the boy in the following ways: translate his bizarre statements into everyday language whenever possible; talk to him as much as possible in simple words about concrete, pleasurable activities—eating, blockbuilding, ballplaying, woodworking.

Feeling more confident, the teacher was able to carry out this plan. She and the guidance counselor continued to discuss David's behavior periodically. By the end of the term David's verbal behavior was greatly improved.

Because of the pressures of time and the inadequacy of funds, many teachers work with classes of disturbed children without the aid of a mental health team. This is unfortunate. No one person alone can understand the needs of all the children in a class for maladjusted children. Some teachers have been hurt by trying to do so; in some instances the special class has degenerated into chaotic destructiveness.

In brief, a working team that includes the teacher and mental health specialists can perform five essential functions to enlarge the potentialities of the special class for helping disturbed children:

1. *Supporting the teacher:* The knowledge that she is working with others toward a common goal can keep a teacher from becoming prey to discouragement, anxiety, and the feeling of being hopelessly overburdened. The team also provides her with an outlet for expressing the strong feelings that inevitably arise over the frustrations encountered in working with disturbed—and disturbing—children.

2. *Providing vital information:* Team members of different professions are equipped to gather and interpret special kinds of information relevant to working with a disturbed child. Psychiatric interviews, psychological tests, data from social casework histories, and medical records may be critical in shedding light on the meaning of a child's behavior and on possible approaches to helping him.

3. *Acting as a sounding board:* The team helps the teacher become more aware of her own attitudes, feelings, and behavior and how they influence individual and group dynamics, and gives her perspective for evaluating her ideas and plans and the occurrences in the classroom.

4. *Participating in the formulation of plans for individual children and for the group:* The team helps

the teacher set realistic expectations and appropriate goals, and suggests approaches to specific problems.

5. *Providing, or arranging for, supportive services:* These may take the form of family counseling, individual psychotherapy for the child, or an after school recreation program.

In summary

The standard kind of educational planning often fails in a classroom for the emotionally disturbed because it is based upon premises about children that do not always hold true for seriously disturbed children. What the teacher who is new to this type of class must do before, during, and after giving her attention to content, methods, and materials, is strengthen her insight into the personality dynamics, perceptions, beliefs, abilities, and disabilities of these children. The most difficult aspect of planning for disturbed children is the translation of such insight into appropriate goals, methods, materials, and educational content.

Many of the principles I have here outlined for teaching special classes of emotionally disturbed children are also relevant for teaching regular school classes. It would indeed be hard to find a classroom that did not house two or three "difficult" or "difficult to get to" children. Better insight into the effective communications between teachers and children, reexamination of the relevance of standardized teaching methods and content, and planning individually for troubled children by a team of mental health specialists and educators might lead to rapid improvements in many schools in which behavior problems are rampant.

¹ The Elementary and Secondary Education Act of 1965, Public Law 89-10. Title I, sec. 201.

² The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Public Law 88-164. Title III.

³ Bruner, Jerome: On coping and defending. In *Toward a theory of instruction*. Belnap Press of Harvard University, Cambridge, MA 1966.

⁴ Hay, Louis: How the classroom teacher can help the troubled child. *The Nervous Child*, vol. 10, no. 3, 1954.

⁵ Cohen, Rosalyn, et al.: An inquiry into variations of teacher-child communication. In *Educational programming for emotionally disturbed children*. (Peter Knoblock, ed.) Syracuse University Press, Syracuse, N.Y. 1964.

⁶ Personal communication from Lestina M. Grant, clinical psychologist, Bureau of Child Guidance, New York City Board of Education.

⁷ Kornberg, Leonard: A class for disturbed children. Bureau of Publications, Teachers College, Columbia University, New York. 1955.

A HEALTH SERVICE PROGRAM

for children in day care

FANNIE EISENSTEIN

"I don't want to lie down on the couch, I want to lie on your lap," said the little 4-year-old girl at the day-care center to the doctor from the Communicable Disease Center (CDC) of the U.S. Public Health Service.

"OK," he replied, "climb on."

"Stick me easy, man," she requested, settling down on his lap and holding out her arm.

He "stuck her easy" and drew out a specimen of blood.

For this little girl and the other children at the day-care center it had been a big day—they had made two trips to the teachers' lounge to see the doctor: trip number one for measles vaccine shots, trip number two to give blood specimens. Both trips were made as part of a demonstration project and health program being carried on with the assistance of CDC by the Gate City Day Nursery Association of Atlanta, Ga., which operates six day-care centers for children of low-income Negro families in Atlanta and nearby Marietta.

The health program has four objectives: (1) the prevention of ill health in young children; (2) the expansion of direct health services; (3) the education of teachers, parents, and the community on the needs in child health; and (4) effective cooperation between parents, the association, and CDC in health research programs.

Most of the children in the day-care centers come from families in which the mother works, often as its sole support, and of which the mother is the head. Therefore, problems of fatigue, poor pay, and long hours crowd to the fore when these mothers try to provide for their children's health.

The program begins

As they worked with the children and their parents, day-care workers at the centers realized there was a need for more health care for children than the center offered, for it only checked initial immunization and provided periodic health examinations. In September 1965, the Community Organization Department of Atlanta University School of Social Work developed a block placement as a community worker for me as a second-year student. In consultation with my field supervisor, the executive director of the agency, and the agency's medical consultant, I began the health program. Through the program, cooperative relations with local health centers were extended and regularized and caseworkers at the day-care centers, the center directors, and the student community worker (myself) met with public health nursing supervisors and district nurses to discuss and plan for health projects.

One of the first projects was to test the eyesight

of all the children at the centers with the cooperation of the Georgia Society for the Prevention of Blindness. When the tests indicated that further medical examination was necessary, parents were informed of the need, and the caseworker helped parents with referrals and appointments, as needed.

In all, the society's team recommended further examination for 18 children, most of whom were consequently fitted with glasses at private or public clinics or by private physicians. In addition, the Ben Massell Optometric Clinic, part of a private agency serving low-income people in Atlanta, gave the agency's social workers useful information on perceptual testing and training materials for preschool-age children. Each center received printed instructions on perceptual exercises and material with which to conduct daily group programs.

We also developed a program of dental education, examination, prophylaxis, and treatment with the cooperation of the Ben Massell Dental Clinic. Although emphasis in the dental program is on prevention—on the topical application of fluoride and on education—it includes extraction and restorative work.

The clinic sets aside a morning a month for each day-care center. A caseworker and the student community worker take seven or eight children at a time to the clinic in the association's station wagon as a field trip. The first round of trips—for children with the most glaring needs—has been completed; the second round is under way. Appointments for further dental care are made at the clinic as needed.

Because the Ben Massell Dental Clinic, overcrowded and understaffed like most clinics, could not give us all the time we needed, we sought the help of the dental division of the Fulton County Health Department. The department told us that during the school year it was so swamped with the work of examining the teeth of schoolchildren it could not consider taking on a program for preschool-age

children. The director of the county dental division, however, agreed to include in the schedule for the summer months dental examination and the topical application of fluoride for the children in the day-care centers who had not been taken care of by the Ben Massell Dental Clinic. This part of the program was accomplished last summer.

In the conference with local health centers, we raised the question of getting measles vaccine for the children in the day-care centers. The health workers thought the idea commendable, but said that vaccine was not available for want of funds in the county and the State. We had to turn in another direction for support.

Service and research

On the hunch that where general funds for universal provision were lacking special funds might be available for a research or a demonstration project we discussed the matter of a demonstration project on measles vaccine investigation with the Communicable Disease Center in Atlanta. From the discussion we found we could not only get vaccine for our children but could also take part in a general health surveillance program. The center was eager to explore the possibility of conducting a surveillance program involving preschool-age children in a normal community. A demonstration program was arranged, therefore. The essence of this cooperative venture between parents, the Gate City Day Nursery Association, and the Communicable Disease Center is the coordination of health programs for the children with the research and surveillance programs of the Communicable Disease Center.

A method of closely watching illness among the children was developed to permit the systematic collection of data and the early detection of outbreaks of illness. Absences and the medical reasons for absences are noted on the weekly attendance records for all children in the six day-care centers. The basic information for the surveillance and tracking procedures of the CDC staff is provided by these records; a history of the health of each child based on the center's information on immunization, past and present illness, allergies, therapy, and family health; and blood specimens (taken, of course, only with the permission of the parents). As needed more specific and detailed information is obtained from the parents by telephone or on home visits by physicians from the Communicable Disease Center and staff members of the day-care centers.

What Fannie Eisenstein has to say in this article about the Gate City Day Care Centers is drawn from field experience as a graduate student at Atlanta University School of Social Work assigned to the project. She is now research director of a program aimed at turning potential teenage violence into social action, sponsored by the United Community Centers of Brooklyn, N.Y. She has also directed the nursery schools of the Jewish Community Centers of Denver.



The program has three parts: care (direct service), study (research), and education. Each part of the project has its own objectives.

The direct service program has three major objectives: (1) immunization of the children against measles; (2) immunization of the children against influenza; and (3) provision of comprehensive medical consultation.

The research program has two major objectives: (1) to study all outbreaks of illness when they occur in the day-care centers; and (2) to study the booster effect of exposure to measles among children immunized or naturally immune to the disease.

The major objectives of the education program are two: (1) to accent prevention in safeguarding the health of young children; and (2) to interpret to parents the relation between study, care, and prevention.

Vaccination activities

When the idea of the study was first broached, several staff members raised the question of how parents would respond. To insure that their response would be tied to knowledge and understanding of the program, we sent all parents a packet of three simple items: a letter explaining the program and its purpose; a fact sheet on measles vaccine explaining what it does, why it is needed, who should get it; and a permission form. Moreover, we encouraged them to call or come to the centers if they had questions. The centers followed the same procedure for their influenza vaccine program.

Permission was received from the parents of 137 children authorizing the centers to give measles vaccine and to take blood specimens. In addition, several parents added notes to the permission form saying their children had already had the measles but giving us permission to take blood specimens.

The 137 children included almost all of the preschool-age children in 5 day-care centers who, to their parents' knowledge, had not had measles.

The sixth center, the Bowen Homes Day Care Center, did not participate in this part of the program because 15 cases of measles were reported before we were ready to start the vaccination. After studying the dates of incidence and the pattern of spread of the disease, CDC physicians decided it would be useless to give measles vaccine at Bowen at that time. However, they gave 137 injections and took 133 blood specimens at the other centers (the physician found it too difficult to draw blood from 2 children; the

other 2 were picked up by older brothers or sisters before he had time to take specimens from them).

We discovered later that the children at another center, the Lyman Homes Day Care Center, had already been exposed to measles—one little boy had come down with the disease 12 days before the administration of the vaccine. The vaccine, therefore, was given too late; measles broke out at Lyman. The center explained to the parents what had happened and answered their questions about the vaccine, the disease, and so forth. Although distressed that they could not prevent the outbreak of measles, center workers did get information for research on time as an element in the administration of measles vaccine that proved valuable to the CDC research program. Now that surveillance records are being filed every week with CDC, this kind of error should not recur.

Information was gathered at the Lyman Homes Day Care Center and from visits to the homes of the children by members of the CDC medical team and the center's caseworker. Parents were interested and even excited by the idea of their children being involved in a health study program and cooperated fully with the physician in pinpointing time and symptoms and constructing histories.

During a discussion about the influenza vaccine at the Bowen Homes Day Care Center, parents said they were interested not only in the vaccine but also in the facts that the physicians were concerned for children and were trying to learn new things. They raised no objection to having two blood specimens drawn, one at the time of vaccination, the other a month later. They said they were glad to participate in this kind of medical program because it would help their children and other children as well.

Thus, the centers are cooperating not only in extending direct services to their day-care children, but also in widening the knowledge on communicable disease in all children.

Had measles vaccine been available through the local health centers when we first checked this year, the outbreaks at Bowen and Lyman could very likely have been prevented. The county health department recently announced that vaccine may be available in Georgia before the end of the year.

Parent education

Many questions came to mind when we started this health care program, notably this one: Are we taking over for the parents, doing the job they should be doing for the health and protection of their children?

We found that we could not examine the question of policy without examining the situations that the parents faced. The many mothers who were the sole support of their households faced the loss of not only a day's pay but also of employment if they took a day away from their jobs, which are mostly as domestic servants or in cleaning services in hotels, department stores, and offices. The loss of a day's pay could mean having to go without several meals. Could any mother ask her family to go hungry at the moment to prevent future pain?

The fact that the day-care centers organized the provision of medical care, for example, and took children in groups to the dental clinic did not relieve the mother of her concern for her children's teeth: Often our work animated her concern, made it possible for the first time for many mothers to think about ways of dealing with the problem of their children's teeth not on an emergency basis only, when pain comes like a blow and decay is in progress, but also on a preventive basis, which underlies the importance of care and prophylaxis. The mothers' concern and interest showed in the special care with which the children were dressed on the days they had appointments at the clinic.

The caseworker or a social work student on field placement (first-year casework student) saw every parent whose child went to the clinic and explained the program, recorded the information required for eligibility, and had the parents sign the child's registration form.

Every parent was informed by telephone or letter of the work done at the clinic—such as the topical application of fluoride, cleaning and polishing, extraction and restoration.

There are three ideas behind the parent education program. The first is that there is a reinforcing relationship between expectation and aspiration. The more opportunities that become possible in the way of health, the more parents want for their children. The second idea is that of providing a model of what a child should have available in health services and what he has coming to him. The third is that of community responsibility. Safeguarding the health

of children is the responsibility of the entire community—parents, special agencies serving children and families, and governmental agencies that supply resources for expanding knowledge and health.

Some changes

The program brought about changes in other directions, as well as in health. During the eye-testing project, for instance, several teachers in the centers became more keenly aware of the children's levels of response and were able to reshape methods of presenting games and play accordingly. It also brought opportunities to the children for new experience of social value. Visits to the Ben Massell Dental Clinic, for instance, provided an opportunity for Negro and white children to meet normally and casually while waiting for the dentist.

Cooperating in filing the absenteeism reports with the CDC for their surveillance records sharpened the day-to-day knowledge of our casework staff to absence due not only to illness but also to conditions in the home. The centers had always kept accurate attendance records and workers always asked parents to inform the centers of the cause of absence, but the additional purpose of helping health research and surveillance puts a renewing accent on the meaning and purpose of the procedure for both parents and staff members.

The broadening of the health program brought more of the community into the day-care centers, for instance, the volunteers who administered the eye-testing program for the Georgia Society for the Prevention of Blindness and the medical teams of the Communicable Disease Center.

The health program was reinforced by other programs developed through the community organization fieldwork placement. These included a children's theater program sponsored by the day-care centers in the communities served; an information service on jobs, training, and examination for teenage brothers and sisters of the day-care children by the centers; and involvement of parents in citizen action in the community.

SOCIAL STRATEGISTS for URBAN DEVELOPMENT

some impressions of the 13th International Conference of Social Work

KATHRYN CLOSE

More than 2,700 persons from 74 countries attended the Thirteenth International Conference of Social Work in Washington, D.C., from September 4-10, 1966—the first meeting held by the conference in this country since its postwar reconstruction in Atlantic City and New York in 1948. With the theme "Urban Development—Its Implications for Social Welfare," the participants were faced with a problem clearly urgent in nearly every part of the world: how to combat the dehumanizing effects of the increasingly rapid urbanization of the world's population. One implication was repeatedly identified from the speakers' platform and in reports prepared before and during the conference: Social workers the world over must become social strategists and play an integral part in the physical, economic, and social planning for urban development.

Twenty-seven countries had prepared reports for the conference, and there were noticeable similarities in the points these made as in many of the speeches and in the reports of the concurrently meeting commissions and study groups. They pictured sprawling, disorganized metropolises, choking from inability to digest the hordes of people flocking to them; and of vast slums packed with newcomers ill-prepared educationally, vocationally, or culturally for urban living, and confused, despairing, and hostile because of their inability to find employment, decent housing, or social acceptance. They

described the resulting individual, family, and community disorganization; the devastating psychological effects of rootlessness among young people cut off from large extended families, traditionally the providers of direction and support; the alienation experienced by men who find themselves shut off by hostility or indifference from access to the affluence they see around them; the breakdown of parental controls in families where the children rather than the parents are the transmitters of the new mores.

Common problems

"Developed" and "developing" countries were reported as experiencing the same problem, differing only in degree and pattern. The developing countries are still largely rural but with a pace of urbanization far more rapid than in the developed countries, in some instances tripling or quadrupling the population of cities in a decade. In Africa, for example, the populations of Accra, Ghana, and of Luanda, Angola, have tripled in the last 10 years and that of Conakry, Guinea, has quadrupled in 5 years. In Latin America, in the 20 years following 1940, the populations of São Paulo, Brazil, Lima, Peru, and Mexico City, Mexico, tripled, while in Caracas, Venezuela, the population increased 5 times. In Hong Kong, the population has increased from 600,000 to 4 million in the last 20 years.

On the other hand, in some highly developed countries, which have become

almost completely urbanized, the pace of urbanization is slowing down: Great Britain, Belgium, and the Netherlands, for example, are now between 75 and 80 percent urban; the United States, 70 percent; Canada, nearly 70 percent.

Predictions that the population of the world would be doubled within 34 years lent the conference a sense of urgency. In the United States, for example, the total population is expected in 44 years to reach 400 million, exceeding the present population of India, and 95 percent to be living in urban areas; while in India the population is expected to reach nearly 1 billion in the same period. One prediction for the city of Madras put the population at 80 million by the year 2050.

From everywhere came reports of inadequate housing. In the developed countries the cities have tended to decay at the center as the oldtime population flees to the outskirts for more air and space and—when racial differences and prejudices are involved—to escape the newcomers. In the United States, it was reported, the creation of new housing has fallen far behind the creation of new slums.

In developing countries, the slums are usually shanty towns around the rim of the cities, which provide them with no services of any type. One-twelfth of the population of the world, it was reported, are living in such shanty towns. Hong Kong is not only rimmed but topped by shanties. There, among the 620,000 "squatters" who live in illegally built, makeshift shacks are 58,000 who

dwell on the top of tenement houses. In Calcutta, India, where nearly one-third of the population live in slums, about 30 percent of the slum dwellers live in one-room "homes," shared with two other families, 15 percent live in shops, and 17 percent have no homes at all.

Resources for coping

While the dehumanizing effects of runaway urbanization were described as similar in all parts of the world, the countries' abilities to cope with them were not. The developed Western world, it was maintained, has the resources, energy, and technical ability to remake the physical, economic, and social environment into a rich and diversified garden in which every man could find nourishment for his highest potentials.

But the developing countries were said to be caught in a bind—with resources too undeveloped to produce the technical capacity for appreciable development without outside help. In some of these countries, the need for economic development was said to be so overwhelming as to overshadow the need for social programs. However, the fact that in so many of the newly independent countries a minister of social welfare was one of the first government officials appointed was cited as evidence that the social needs of people were not being overlooked. Some delegates from these countries saw in their newness an opportunity to avoid the mistakes that have been made in the old cities of the developed world.

Directions for planning

Nearly all speakers and reports advocated interdisciplinary planning in anticipation of population movements as essential. But they differed in suggested directions.

There were those who spoke up for the values of rural life—close family and neighborhood ties, the absence of clutter, the less frantic pace of living, an adherence to traditional religion. They suggested that the rush to the city could be slowed down by efforts to improve the access for rural people to good medical care, jobs, social services, and stimulating leisure-time activities.

The gaps between rural and urban life were reported to be widening in some of

the developing countries. Some reports, however, pointed out that the gadgets and manners of urban living are as familiar to country as to city dwellers, at least in some parts of the developed world, through "the invasion" of the country by city commuters, the decentralization of industry, the omnipresence of the automobile, the multiplication of roads, and especially the mass media of communication. But not all the effects of this rural urbanization were presented as salutary. For example, in one highly developed country of Europe where rural villages have been invaded by city commuters, newly created class distinctions have resulted in resentment and friction.

Many conference participants, however, saw no need to arrest the trend toward urbanization, nor indeed any possibility of doing so, but a great need to build urban environments in both new and old cities that would fulfill the city's function as a civilizing force. Such planning, it was asserted, must begin with the recognition that what young people are seeking when they flock to the city is the chief advantage of urban life, the possibility of making independent choices—in jobs, friends, services, training, intellectual pursuits, consumption, and leisure-time activities.

Seeing that the urban environment actually provides this possibility of choice is a task of the social worker, it was maintained, as is seeing that rural people are helped before and after migrating to the city to know what to expect there and what is expected of them.

Some of the values of rural life might be retained, it was said, if an "ecological approach" were taken to urban planning—an effort to retain the relationship of man to nature and to avoid exploitation of either.

Architects and town planners on the program described new towns being built in England, the United States, Brazil, and Venezuela and called for social work participation in helping planners provide for human needs. One warned that unless new towns were "socially balanced" they would become "rugs under which the poor are swept." Another spoke of the immediate necessity of providing slums, "a semi-permanent fact of modern urban growth," with the basic services to sustain family life, encourage upward mo-

bility, and develop community life—sanitary facilities, garbage collection playgrounds, schools, vocational training centers, and churches.

A sense of community

Social planning, the conferees were repeatedly reminded, implies attention not only to the provision of social and health services, but also to the means for people to develop a "sense of community," particularly lacking in the slums. Thus social workers were urged not only to take steps to see that the kinds of facilities and services that encourage neighborliness and community involvement are strategically located but also to encourage the "maximum feasible" participation in policy decisions of the people to be affected by them, "rich and poor alike," youth as well as adults.

Methods suggested to bring about such participation were: the decentralization of government to make it more responsive to local needs, as in the Basic Democracies of Pakistan; the application of community development techniques used in the villages of India to the organization of community action committees as in antipoverty program in the United States; and the establishment of multipurpose neighborhood service centers to give people a channel for voicing their needs and wishes. There was, however, a warning against allowing self-appointed pressure groups to usurp the role of elected representatives of the people.

About children

Children received attention at the conference chiefly as the victims of the family disorganization resulting from rapid urbanization: lost, homeless children who band together to form substitute families of their own; children used as messengers in a rampant trafficking in drugs; children unprotected from all the health hazards of overcrowding and lack of sanitation and water; children emotionally abandoned by despairing parents; children subjected to the thousand daily indignities of conscious and unconscious racial discrimination.

In the study group on children, composed of 45 persons from 19 countries, the differences in service needs because of differences in country resources an-

customs became evident. For example, neither homemaker services nor income maintenance programs—considered necessary in most countries of Europe and North America—are regarded as feasible in countries where large extended families are still predominant. However, where the extended family system is still strong, countries generally rely on institutional care rather than on foster family care or adoption for homeless children or children born out of wedlock. On the other hand, interest in the provision of day-care services for children of working mothers seems to be growing everywhere because of increasing participation of women in the labor market.

The study group discussions revealed also that differences in resources and stage of development between countries account for differences in service priorities. Many developing countries give "human investment" programs such as vocational education priority over individualized services for children with special handicaps, leaving the total well-being of all children as a "goal for tomorrow." In countries with more highly developed resources, however, greater emphasis is put on refining services to children with special problems, such as taking steps to individualize services for children and adolescents brought before the courts for delinquency or neglect.

A discussion of family planning services in this study group revealed great disparity in the availability of such services among the 19 countries represented, but also some evidence of a growing interest in changing prohibitive government policies. In England, for example, help with family planning is provided to married women only, but there is increasing discussion about the advisability of extending the service to unmarried women. In France, where help with family planning can only be provided clandestinely, a well-publicized movement seeks to mobilize public opinion for a policy of approval. In India and Pakistan widespread family planning services receive strong government support. On the other hand, in some countries of South America

family planning services are strictly forbidden and all but unknown.

Despite these differences in emphases, the study group on children arrived at a number of targets for social work efforts. These included services to strengthen family life (all representatives indicated this as an expressed goal in their countries); services to supplement family care in urban development; comprehensive and coordinated health and educational services for children; increased social work research; changed professional and public attitudes in relation to such areas as family planning, adoption, unwed mothers and their children, and more balanced service for girls; adherence to the UNICEF declaration on the rights of the child; the development of a national policy in relation to children; and a more competitive approach toward securing a fair share of funds for social purposes beamed toward preventing future problems as well as protecting children.

Social work education

There was explicit recognition in the conference, as there had been at the International Congress of Schools of Social Work held the previous week, that if social workers are to play a more forceful role in urban development those responsible for social work education must lift their sights to take this into account.

One proposal was for the development of two types of social workers—the traditional caseworkers and group workers, trained in the diagnosis and treatment of individual and social problems, and social strategists with knowledge of economics, tax structures, laws, and politics, trained to work at policy levels with government officials, industrialists, and legislators. Schools of social work, it was also suggested, should work more closely with schools of architecture, public health, education, and other units of universities, including the new institutes for the study of urban problems. But proposals that greater emphasis be put on training social work generalists, geared to social action, brought some

expression of fear that the special nature of the social work profession might be lost.

The need for expanding schools of social work everywhere, but especially in the developing countries, was repeatedly stressed. Some delegates deplored the modeling of social work in their countries on the U.S. pattern and advocated that aid efforts be focused on helping them build up their own schools with training closer to their countries' needs and culture. The United States, it was maintained, could learn a great deal from some of the developing countries about the usefulness of indigenous "social animators" and mutual aid associations in bridging the cultural gap between the professional and client, as well as in alleviating the social work manpower shortage.

A force for civilization

There was a great deal of emphasis in the conference on the importance of research, on the need to know more about the way people live in neighborhoods; about why they do or do not use the services provided them; about how to measure the effectiveness of services.

But the conferees were also warned against an excess of professionalism lest it lead to "the indifference of wisdom" and add to the technical age's greatest threat to civilization—destruction of man's sense of identity and hence his relationship to his fellowman. Calling for "an excess of feeling, of caring, and decency" one speaker maintained that as "a prime civilizing force" social workers must "force world society to recognize that people die inwardly from being nameless and faceless, from not having roots in the community . . . and from having to react endlessly to a thousand small, uncaring ways."¹

The conferees responded to this challenge with a standing ovation—perhaps an indication that in it they recognized the ultimate goal for developing the reach and skill of social work.

¹ Young, Whitney M., Jr., executive director, National Urban League, New York.

HERE and THERE



White House Conference

The first steps toward a 1970 White House Conference on Children and Youth were taken last August by the Secretary of Health, Education, and Welfare, John W. Gardner, when at the request of the President he wrote to the Governors of the 50 States, Puerto Rico, Guam, the Virgin Islands, and American Samoa and the president of the Board of Commissioners of the District of Columbia asking for their support. In the letter, the Secretary asked each Governor to appoint a State committee to plan for the State's participation in the Conference, to act as liaison between the Governor and a national committee to be appointed by the President, and to work with the staff of the national Conference. The Conference's staff will be attached to the Children's Bureau.

By mid-October, the Secretary had received 36 affirmative responses. In most States, the Governor had appointed or was about to appoint an already existing State committee for children and youth to work with him for the proposed 1970 Conference.

Family planning

Whether or not unmarried women and girls should have access to family planning services came under discussion at two meetings focused on public family planning services, held in September. One, in Roanoke, Va., September 7-8, was sponsored by the Department of Health, Education, and Welfare for persons in key positions in the health, education, and welfare programs within the 12 Appalachian States. The other, held in San Francisco, Calif., September 19-20, was sponsored by the Searle Refer-

ence and Resource Program for persons engaged in the operation or support of public family planning clinics.

The Roanoke meeting was the first of nine regional meetings on family planning planned by the Department, the others to be held in Atlanta, Dallas, Kansas City, Denver, Chicago, New York, and Boston. Its 200 participants focused their attention on the current availability of family planning programs, the social and economic aspects of providing them in various types of settings, and the resources for supporting educational, research, and service programs in family planning. The discussion revealed general agreement on the importance of access to family planning service for married women at all socioeconomic levels, but divided or uncertain opinions on when, if ever, such service should be provided to unmarried women or girls.

At the San Francisco meeting, where similar ambivalent attitudes were reported to be held by some workers in this field, the dinner speaker, Katherine B. Oettinger, Chief of the Children's Bureau, put family planning services in a framework of health and family protection and urged their extension to all who need them. Pointing out that 50 new maternal and infant care projects and many other maternal and child health programs supported by Federal-State funds do offer family planning services to unmarried mothers who have already produced a child, she said that the best possible health, education, and welfare resources should be made available to minimize the problem of unwanted and irresponsible pregnancies, especially among teenagers, the group "most vulnerable" to unstable family relationships. She especially stressed the need for family life educa-

tion and sex education from preschool through college levels.

Other sessions of the San Francisco meeting were focused on strategies for educating the community to the purpose of a family planning clinic, methods of reaching and keeping the client, ways of planning and evaluating a clinic's objectives and progress, and resources for support.

For youth

Young parents are to be the first focus of a new Children's Bureau program of youth services directed at facilitating the transition of all youth to responsible adulthood. The program which is being developed through the Bureau's newly established Youth Services Unit, under the leadership of Dr. Catharine V. Richards, will be directed toward identifying the problems and needs of adolescents and young adults in today's changing society, exploring existing resources for meeting these needs, and stimulating new approaches for dealing with them. Its long-range goal is to promote the development of a network of synchronized public and voluntary systems capable of providing a social structure in which young people can develop their potentialities as individuals and as competent contributors to the maintenance and development of democracy.

Both married and unmarried young parents were chosen as the first concern of the new program because the high risks of unstable family relationships in these young people are a detriment not only to their own well-being but also to the well-being of their children and of society. It has been estimated that 600,000 girls between the ages of 14 and 19 have children, and that 40 percent of the more than 250,000 children born out of wedlock each year are born to girls under 20. Figures from some States also indicate that marriages of teenagers break up in divorce three to four times more frequently than other marriages.

The new program will, therefore, work toward the promotion of sex education and family life education through public and voluntary agencies, to supplement what is being done in this direction through the schools; the extension of community programs of parent education directed especially to young parents; and the provision of

egrated medical, psychological, educational, and social services to unmarried mothers.

Dr. Eleanor Brown Luckey, specialist in family life education at the University of Connecticut, will spend a year at the Children's Bureau, on loan part time from the university, to help get the program for young parents under way.

The first of five projected conferences of representatives of State committees on children and youth to identify the problems of young people today and possible directions for meeting them was held in Washington, D.C., September 22-24, under Children's Bureau auspices. The 18 participants came from committees in Delaware, Maryland, New Jersey, Pennsylvania, West Virginia, and the District of Columbia, and included three youth representatives—two high school students and one recent college graduate.

One of the problems the participants identified as most important was the widening of the distance between the generations by the rapid technological developments and social changes of the century and the consequent need of parents and other adults for help in understanding and relating to adolescents. Other needs stressed were: cooperative activities between adults and young people in community planning and improvement; increased and challenging opportunities for young people—commensurate with their abilities and energy—in education, employment, community service, and participation in community affairs; widespread opportunities for young people to build close relationships with their peers and with adults in an increasingly impersonal society; and greater cooperation between organizations interested in the welfare of youth at Federal and State levels and in communities and neighborhoods.

Similar conferences with the purpose of assessing conditions and suggesting action for change were held in Boston, Mass., and Atlanta, Ga., in October and will be held in Omaha, Nebr., and Salt Lake City, Utah, in November.

Three hundred teenagers attended conferences on youth and alcohol at Erie and Meadville, in northwestern Pennsylvania, September 30 and October 1, respectively, the first such con-

ferences to be held in six geographic areas of the State, under the sponsorship of the Governor's Advisory Council on Alcoholism and the Committee on Children and Youth of the Governor's Council for Human Services. The area conferences are the result of a statewide conference on youth and alcohol held in Philadelphia last April under the same auspices and are intended to generate additional conferences on countywide bases, thus reaching young people in every part of the State. Their purpose is to give the young people an opportunity to express their ideas on the extent of and reasons for drinking among teenagers, to provide them with information about the chemical reactions of alcohol on the body and the nature of alcoholism as a disease, and to strengthen their ability to make wise decisions in relation to drinking.

A questionnaire answered by 143 of the young people who attended the statewide conference indicated that 68, or nearly half, drank once in a while, usually to celebrate an occasion or simply for enjoyment.

Family life education

Under a policy issued late in August, the U.S. Office of Education has made clear its willingness to offer financial help, under its already established programs, to educational institutions and community agencies to start or to improve programs in family life education and sex education. The offer applies to all levels of educational programs from preschool through graduate programs, including programs for adults and educational research. The funds may be used not only for classroom instruction in sex education and family life education but also for the training of teachers, counselors, and health workers in these subjects.

Projects on or including family life or sex education are eligible for support through these Office of Education programs: aid to schools in low-income areas; supplementary centers and services for elementary and secondary schools; university leadership for urban progress; vocational and technical education; counseling and guidance institutes; institutes for advanced study; adult basic education programs; educational research and training; and library services and construction. Initiation of such projects and their sub-

stance remain a matter of State and local choice. In most Office of Education programs, Federal funds are channeled through State agencies.

The Office has prepared fact sheets about the program through which support for family life education can be received and guidelines for applying for funds under title I (aid to schools in low-income areas) and title III (supplementary centers and services) of the Elementary and Secondary Education Act of 1965.

Social work training

In a two-way program conducted last summer—two way in that it was designed to benefit both instructors and students—121 faculty members from 31 schools of social work spent from 3 weeks to 3 months in public welfare agencies in 25 States, the District of Columbia, and Guam on projects demonstrating new methods or new uses for existing methods of administering federally aided public assistance programs. Through the projects, social workers and supervisors received on-the-job training under the faculty members, and faculty members had opportunities to gain field experience that could broaden the base of their teaching.

In one State, for instance, six faculty members, working with the program planning and development staff of the State welfare department, prepared guidelines for social workers to use in assisting welfare clients and low-income families. In another, nine faculty members conducted intensive training programs for caseworkers with little or no academic training. In a third, two faculty members worked as consultants to students from schools of social work who were receiving on-the-job training during the summer.

Demonstration grants totaling almost \$312,000 from the Welfare Administration of the U.S. Department of Health, Education, and Welfare supported the program.

During fiscal year 1966 (July 1965-June 1966) the Children's Bureau awarded about \$5 million in grants to 66 schools of social work and to 2 other higher education institutions in 33 States, the District of Columbia, and Puerto Rico to conduct projects in professional training under the child wel-

fare training grants program. The program supports three types of projects: teaching programs for field instructors and other faculty members; traineeships at both the master's and doctoral levels; and short-term training programs, all for persons working in or intending to work in the field of child welfare. By categories the 1966 grants were made as follows: 154 teaching grants totaling \$2,428,317; 727 traineeships totaling \$2,399,275; and 21 short-term projects totaling \$172,391.

The amounts granted have increased each year since the program began in 1963. In fiscal year 1963 the Bureau granted \$199,133; in fiscal year 1964, \$1,805,444; and in fiscal year 1965, \$3,578,579.

International health

The Children's Bureau recently added two new aspects to its international research program in maternal and child health: (1) the provision of opportunities for U.S. experts to study problems and developments in other countries and for experts from other countries to come to the United States for study, observation, and consultation; and (2) the provision of opportunities for senior medical students in this country to engage in short-term research studies abroad. All travel and maintenance are paid through U.S.-owned foreign currencies.

Only a few highly qualified experts, such as professors on sabbatical leave from schools of medicine or public health, will be selected for study abroad in the interchange of experts program. The medical students for the foreign research studies are being selected from referrals made by the deans of the medical schools in this country, all of which have received notice of the program. They will engage in research projects funded by the Bureau in Egypt, India, Israel, Pakistan, and Yugoslavia. Three students, selected early last summer as the first to participate in the program, have already completed studies in Egypt, Israel, and Pakistan.

The Bureau is now funding 18 research projects in different aspects of maternal and child health in 6 countries—Egypt, India, Israel, Pakistan, Poland, and Yugoslavia. These include studies of: prematurity; toxemia of pregnancy; infant mortality, morbidity, and growth and development of chil-

dren of various social and ethnic groups; the incidence of and screening methods for phenylketonuria; the incidence and detection of deafness and hearing loss in children; the cause and incidence of severe mental subnormality; and the effects of the introduction of contraceptive services on the rate of abortions.

Child health

The National Institute of Dental Research (NIDR) of the U.S. Public Health Service recently announced the development of a new, easily administered, method of applying fluoride to children's teeth. By using a plastic mouthpiece, similar to those worn by athletes, a jellylike material containing 1.1 percent sodium fluoride is forced into pits and fissures of the teeth and into the gums undiluted by saliva. One dental hygienist can effectively supervise many more children with the new method than with the methods of topical application of fluoride that are now used.

NIDR tested the new method over 2 years in Cheektowaga, N.Y., a community without fluoridated water. About 300 children were the gel-filled mouthpiece for 6 minutes each school day; 200 others, used as controls, were not treated but were kept under surveillance. The children in the control group developed over four times as many new decayed, missing, or filled tooth surfaces as those treated by the new method. Many of the children who were treated developed no new cavities during the testing period. NIDR points out that the findings of this test add to the evidence that fluoride strengthens the teeth and makes them more resistant to decay.

PHS plans to run two additional tests on the method: one in an area having fluoridated water to determine whether repeated topical application of fluoride confers additional protection, and another to determine the effectiveness of weekly, rather than daily, applications.

American Indians and Alaskan natives (Eskimos, Aleuts, and Athapaskan Indians) can expect to live longer than ever before because fewer of their children are dying in infancy and their general health is improving, according

to recently published figures of the Public Health Service.

The figures show that an Indian child born in 1964 had a life expectancy at birth of 63.5 years as compared with the 51 years of an Indian child born in 1940. However, a child born in 1964 in the general population had a life expectancy at birth of 70 years. The infant mortality rate among Indian children dropped 45 percent between 1954 and 1964—from 65 to 35.9 deaths of infant in the first year of life for every 1,000 live births—but was still 1½ times greater than for the general population. During the same decade, the infant mortality rate among Alaskan natives dropped 34 percent, from 83.4 per 1,000 live births to 54.8. For all other U.S. citizens the infant mortality rate was 26.5 in 1954 and 24.8 in 1964.

The incidence of respiratory illnesses, gastroenteritis, and diarrhea, the diseases that have been the leading killer of Indian and Alaskan native children has also been greatly reduced—a fact the PHS attributes to immunization programs for children and the greatly improved conditions of sanitation under which Indians and Alaskan natives live.

Obstetrical services or conditions associated with pregnancy continue to be the main reasons for admission to hospitals for Indians and Alaskan natives. Between 35 and 40 percent of all the general patients, however, are under 5 years of age, and 70 percent of them are under 5.

The figures are included in "Indian Health Highlights: 1966 Edition," available from the Inquiries Branch, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

Research

To protect the rights and welfare of human beings used as research subjects the U.S. Public Health Service (PHS) has issued two policy directives requiring assurances from all applicants for its research grants that protective procedures will be followed and that appropriate means used to gain the subject's consent. In addition, PHS also supporting a study of the ethical questions involved in such research.

The first directive, issued on February 8, 1966, requires all institutions applying for PHS grants not only to submit such assurances of protection

it also to supply a description of the risk involved and of the potential benefits of the proposed research. The second directive adds to these requirements assurance that the work of each individual researcher will be reviewed and remain under the surveillance of a committee of his colleagues before human beings are used as subjects, preferably before the application for a research grant is made.

The study of the ethics of research with human subjects will be carried out by the American Academy of Arts and Sciences, under a PHS grant, through a series of conferences to be attended by physicians, medical scientists, lawyers, biologists, and members of other professional groups. The conclusions will be published in a special issue of the academy's journal, *Daculus*, late in 1967 or early in 1968.

Juvenile delinquency

The 1966 Maryland Legislature has established a Department of Juvenile Services, to be the central administrative agency for juvenile correctional services in the State. The department will have responsibility for institutions, the detention, diagnosis, training, and rehabilitation of juvenile offenders, formerly administered by the State Department of Public Welfare, and for juvenile probation and aftercare services, formerly administered by the State Department of Probation and Parole, the State Department of Public Welfare, and local probation departments.

The legislation establishing the new department provides for an Advisory Board of Juvenile Services to consult with the department, consisting of representatives of the State Departments of Education, Health, Mental Hygiene, Police, and Public Welfare, the judiciary of the State, voluntary child welfare agencies, and the public at large. The law also directs that a study of the State's juvenile correctional facilities and probation and parole services be made by February 1, 1967. At the request of the Governor, the Federal Children's Bureau is carrying out the study.

The Children's Bureau is also conducting a comprehensive study of the cities and programs for juvenile offenders in New York State which are

administered by the New York State Department of Social Welfare. The study will be part of a broader study of all New York State facilities and programs for both adult and juvenile offenders being conducted by the Governor's Special Committee on Criminal Offenders.

Child care

Some 112,000 children were adopted in the United States during 1965, an increase of 4.6 percent over 1964, according to Children's Bureau estimates. The rate of increase was a little lower than for the year before, since 6.4 percent more children were adopted in 1961 than in 1963. More than half the 1965 adoptions—54 percent—were made by persons unrelated to the child, and of these, 69 percent—about 53,000—were made through social agencies—the highest proportion on record, and a continuation of a trend toward agency rather than independent placement for adoption.

An estimated 11 percent, or 15,600, of the children adopted in 1965 were non-white, about the same as the proportion of nonwhite persons in the population, and about the same proportion as in 1964. This proportion, however, was not sufficient to provide for all the non-white children in need of adoption.

From studying 115 foster homes in which 127 disturbed children had been placed, the Foster Homes Research Project of the Wisconsin State Department of Public Welfare has drawn up a list of 10 characteristics found in most of the successful foster homes:

1. Family income was at least average.
2. The father and mother worked well as a team.
3. The family had other children (natural or foster).
4. The father had a relatively high level occupation.
5. The mother received a good rating in handling a hypothetical defiant child on a questionnaire.
6. The parents of the foster mother were not or had not been "highly" religious.
7. The father and his parents had had an affectionate relationship.
8. The mother was rated as "child centered" on an attitude questionnaire.
9. The mother lacked confidence in

her ability to handle a hypothetical withdrawn child.

10. The father exercised "selective firmness."

The project set out to identify (1) the characteristics that distinguish the "relatively" successful foster home from the "relatively" unsuccessful, and (2) the ways in which these characteristics can be included in an intake study of families applying for foster children. Using the Borgatta-Fanshel Child Behavior Characteristics Schedule, social workers through interviews with the foster parents evaluated each foster home on the basis of the child's behavior in line with the goals of the placement.

Investigators for the project also conclude that more research is needed on two related subjects: methods of assessing the success of foster-home placements besides using the judgment of the social worker, and the development of precise ways of assessing the child's behavior and changes in it. Both problems are complex, they point out—particularly the second, as it involves the child's previous experience with neglect, abuse, and emotional crises and his present experience of continuing a relationship with his own family while living with the foster family. They also point out that their findings are exploratory rather than final, but that the investigation may have been "on the right track" toward identifying predictors of success.

The project was supported in part by a grant from the Children's Bureau.

As a basis for refining its programs for recruiting, selecting, and guiding foster parents, Brookwood Child Care, a voluntary child placement agency in Brooklyn, N.Y., recently developed a composite "profile" of its foster parents, based on data gathered on 59 foster-parent couples who had been with the agency prior to January 1965. Fifty of the couples were Negro.

The agency found as positive characteristics the fact that most of these foster parents had come from families that had stayed together in spite of social and economic deprivations, that they themselves were maintaining close family ties, that the foster fathers were steady wage earners, that the couples took foster parenthood seriously (as indicated by their average length of

service—5 years), that home and family were their principal interests, and that their chief reason for taking in foster children was "love of children" rather than the desire for additional income. Most of the foster parents were rated by the agency's caseworkers as "satisfactory" in dealing with behavior problems.

The chief weaknesses found by the agency in these foster parents—on the

basis of caseworkers' ratings—was in ability to deal with highly aggressive children and to handle sexual problems. Another weakness—from the standpoint of the agency's needs—was the overwhelming preference among them for taking in preschool-age children and reluctance to take in teenagers.

On the basis of these findings, Peter C. Rocco, administrative supervisor, who prepared the profile, has proposed

increased agency guidance of foster parents through intensified inservice training for all foster parents and a orientation course for new foster parents. He also proposed the establishment of small group residences for adolescents—a service which has since been inaugurated.

The agency is presently engaged preparing a group "profile" of its foster children.

in the journals

The unwed father

The father of her child is "certainly not a phantom" in the life of the unwed mother, Mignon Sauber maintains in an article in the November 1966 issue of *Welfare in Review*. ("The Role of the Unmarried Father.") On the basis of information obtained from 273 unwed, first-time mothers who had kept their children, the author reports that 3 out of 5 mothers were still in contact with the fathers and that 33 percent of them had lived with the fathers at some time during the 18 months after their children were born. At the end of the 18 months, 15 percent were married to and living with the fathers; another 12 percent were living with the fathers though not married to them. The study was carried out under the auspices of the Community Council of Greater New York, of which the author is research director.

About half the fathers gave some financial support to the mothers during pregnancy, the author reports. About 64 percent of the mothers received some support from the fathers during the 18 months after the birth of their children; at least 4 out of 10 received some help from the fathers throughout the 18 months. No other source of support was so steady. Almost all of the fathers who gave support did so voluntarily. Employed fathers were the ones most likely to give support.

Mothers between the ages of 17 and 24 had more contacts with the fathers than did those under 17 or over 24.

The longer the mother and father had known each other before conception, the longer they continued to have contacts after the birth of their child.

Although the information about the unwed fathers was gathered indirectly through the mothers, the author maintains that it may "add to the growing body of knowledge about unmarried fathers."

Nonthriving babies

The mother whose baby fails to thrive though he seems organically sound may need nursing care herself to help her find satisfaction in motherhood, Juliana P. Rhymes maintains in the September 1966 issue of the *American Journal of Nursing*. ("Working With Mothers and Babies Who Fail To Thrive.") She draws her conclusions from a study of 13 babies ranging in age from 12 weeks to 27 months who were hospitalized because they were not thriving despite apparent organic soundness. The investigation centered on the environment of each child, especially on the mother-infant relationship.

The mothers, the author reports, had certain characteristics in common. Their families were under great stress—stress borne principally by the mother—both emotionally and financially. Most had grown up in chaotic, unstable homes lacking good mothering. They seemed unable to give their children the mothering they needed. All of the babies were the results of unplanned, unwanted pregnancies.

An important function of the nurse she points out, is to help the baby mother respond to him appropriate by acting not as an authority figure but as an "ally or collaborator" in the care of the baby, allowing the mother to progress at her own pace. Where possible, she suggests, the nurse should urge the baby's father or other member of the family to give the mother more support.

The risks of adoption

Alfred Kadushin, writing in the June 1966 issue of the quarterly *Social Work* answers the question he raises in the title of his article in the negative ("Adoptive Parenthood: A Hazardous Adventure?") The hazards of adoption, he maintains, are more apparent than real.

The author reviews 11 studies that report overrepresentation of children adopted by nonrelatives among those referred for psychiatric clinic treatment. However, he raises questions about the statistics employed in arriving at this conclusion, citing claims of research investigators that the base used is too large and the proportion of adopted children in the population has been underestimated. Other questions concern differential use of treatment facilities and lack of clear-cut evidence that symptomatology differs for adopted and natural children.

The author also reviews studies of the outcome of adoptions. In these, he found that 78 percent of 2,000 adoptions were considered "unequivocally successful" and that only 14 percent were considered failures.

His conclusion is that "adoption can be, and most frequently is, a successful venture."

BOOK NOTES

THE ADOLESCENT GIRL IN CONFLICT. Gisela Konopka. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1966. 177 pp. \$4.95, clothbound; \$1.95, paperback.

Because she is often lonely and in despair, the adolescent girl in conflict seeks relief in "the crowd or in the love relationship," only to find they offer temporary relief, according to this book on delinquent adolescent girls. Such girls receive very little help from society, the author contends. She bases her observations on a study made through group and individual interviews with over 180 adolescent girls in Minnesota, aged 14 to 19, of whom 100 had been adjudicated as delinquents, and 76 were in institutions as unruly mothers. The book includes many excerpts from tape recordings of the girls' conversations, which reveal their feelings about themselves, others, and their relationship with the outside world.

The author found that the offenses charged against the delinquent girls were truancy, running away from home, and illegal sexual acts, charges not usually brought against boys. Although boys probably act out sexually more than girls, she contends, such acting out is more evident in girls because of the "meaning it has to the girl herself" and because the public "is generally negative toward it for the girl while tolerant of it for the boy."

The problems of adolescent delinquent girls, the author finds, stem from such sources as being unprepared for puberty, the difficulties in adverse family situations of identifying with an adult, be changing but still anomalous position of women in society, and "faceless" adult authority. She recommends several courses of action as remedy: providing better services to unmarried mothers; improving the status of women in our society; providing constructive coeducational activities for

young people; and putting current knowledge into practice in programs for delinquents.

THE ROLE OF AGENCIES SERVING LOW-INCOME GIRLS. Training Center in Youth Development, Boston University; National Federation of Settlements and Neighborhood Centers Training Center, Chicago, Ill.; Training Center for Delinquency Prevention and Control, University of Minnesota, Minneapolis. Boston University Press, Boston, Mass. 1965. 202 pp. Free on request from Boston University Training Center in Youth Development.

This publication reports on a conference on agencies serving adolescent girls from low-income families held in Minneapolis last year under the direction of Catharine V. Richards, by the three agencies listed above.

The report contains the papers that furnished the framework for the conference, notes on workshops held during the conference, and the guidelines adopted for providing services to such girls.

A summation of conference recommendations suggests four methods of intervention in working with adolescent girls: helping them build respect for themselves and others; providing experience that will strengthen their trust in themselves and others; manipulating the environment; and providing constructive experience for learning how to get along in the world.

DEPRIVATION AND EDUCATION. Mrs. M. L. Kellmer Pringle. Longmans, Green & Co., Ltd., 48 Grosvenor Street, London, W.1, England. 1965. 311 pp. 42s. 6d. net. (Obtain from William Glaiser, Ltd., 294 Croxted Road, Herne Hill, London, S.E. 24, England.)

Deprivation of normal home life can seriously affect the ability of a child to

learn, the author of this book contends. She bases her conclusion on the results of a study she conducted of 142 children, ages 1 to 14, in residential care in England.

The author discusses the effect of deprivation of a normal home life on early language development; the connection between prolonged separation and emotional adjustment; differences in experience and behavior in stable and disturbed children; and the effects of remedial education on the educational attainment of maladjusted children.

The author found that—

- Language development among children in care was more seriously affected by deprivation than any other aspects of development.

- Those children who were regarded as least responsive to teaching efforts were those who had no contact with their parents and other relatives.

Pointing out that the best time to prevent language difficulties among deprived children is in the preschool years, the author recommends that—

- Nursery schools with trained teachers be provided for children from crowded, deprived homes.

- Greater emphasis be placed by caretakers of children in institutions on conversation with and reading to children, and every means used to arouse the child to express ideas, thoughts, and feelings.

- Every child in institutional care be provided a stable, long-term relationship with an adult.

- Ways be found to help inadequate, incomplete families with the tasks of child care and to ease the effect of damaging experiences on children taken into care.

GROUP WORK AS PART OF RESIDENTIAL TREATMENT. Edited by Henry W. Maier. National Association of Social Workers, New York. 1965. 175 pp. \$3.25.

The first of a proposed series of publications on specific subjects related to group work, this collection of 12 essays on residential treatment reflect change in social work, according to the editor, because they are on social group work as part of, not just in, residential treatment. The essays discuss the group work treatment process before placement, during placement, and in residential living.

The examples used are largely taken from residential settings for children.

THE ADOLESCENT EXPERIENCE.

Elizabeth Douvan and Joseph Adelson. John Wiley & Sons, Inc., New York. 1966. 471 pp. \$7.95.

The adolescent is both "pushed and pulled toward the future," according to the authors of this report on a study of over 3,000 adolescent boys and girls in school—the "middle majority"—in all sections of the United States and from all classes of society. A basic assumption with which they began—that the "thrust to the future is crucial to the

adolescent experience"—proved correct, the authors maintain. Orientation to the future was characteristic of the young people who were well adjusted in adolescence; it was markedly absent in those who were not.

Another assumption with which they began, however—that boys and girls would not differ greatly in their responses—proved false, they report. The boys concentrated on acquiring vocational skills that could lead to "modest advances" over their fathers' positions. The girls, on the other hand, concentrated on the "interpersonal . . . on marriage and the roles of wife and mother." The differences between the

sexes were even more marked, the authors hold, in the relation of young people with one another. Group loyalty had much more meaning for boys than for girls. Girls gave the loyalty to "best friends"—to two-person relationships.

Despite such differences, the authors maintain, by and large, these young people were much alike in that they were "heavily invested in middle-class values" regardless of class or geographic location.

The study was conducted for the Boy Scouts of America and the Girl Scouts of America in 1955 and 1956 by the Survey Research Center of the University of Michigan.

Films on child life

Charges for rental or purchase may be obtained from distributors.

A QUARTER MILLION TEENAGERS. 16 minutes; color; sound; purchase.

Designed for use in health and science classes and as a tool in the national program to combat venereal disease among teenagers, this discussion film is directed to teenage audiences. One sequence stresses that VD can be cured if treated in the early stages; animated sequences explain in detail the physiological aspects of syphilis and gonorrhea.

Audience: Junior and senior high school students (in health, biology, and physiology classes); youth groups; student-teachers and other adults who work with adolescents.

Produced by: Churchill Films in cooperation with the Los Angeles City Schools and the Los Angeles County Health Department.

Distributed by: Churchill Films, 662 North Robertson Boulevard, Los Angeles, Calif., 90069.

WILLIE CATCHES ON. 24 minutes; black and white; sound; purchase.

Using a biographical technique, this open-end film depicts the environmental

influences which develop and perpetuate attitudes of racial prejudice in a growing child. The film depicts Willie, a racially prejudiced college student, as a victim of his otherwise advantaged environment and of his own prejudices. It points out the influences present during various periods of his development and traces the progress of his prejudice from infancy to college age.

Audience: Parents and expectant parents, teachers and student-teachers, youth groups and group leaders, and community groups.

Produced by: National Film Board of Canada.

Distributed by: Text-Film Division, McGraw-Hill, 330 West 42d Street, New York, 10036.

TO OPEN A DOOR. 30 minutes; sound; black and white; free loan.

Designed to illustrate the effectiveness of community cooperation in promoting medical programs and financed by a grant from the Public Health Service, this film shows the methods used by one community to reach the segment of its population most in need of health aid and information. Volunteers from

all walks of life—including children and teenage gangs—in Newark, N.J., make up the cast.

Audience: Civic and PTA groups concerned with community health and welfare; State and local public health officials; political leaders; clergymen.

Produced by: New Jersey Department of Health in cooperation with the U.S. Public Health Service.

Distributed by: U.S. Public Health Service Audiovisual Facility, Communicable Disease Center, Attention: Distribution Unit, Atlanta, Ga., 30333.

THE NEGLECTED. 30 minutes; sound; black and white; purchase.

Sponsored by the Children's Bureau and the Pennsylvania State Department of Welfare, Office of Children at Youth, this film portrays the many kinds of impoverishment in families who children are in the care of a community agency because of abuse or neglect. It demonstrates how skilled social workers can help families change harmful relationships that threaten the health and emotional well-being of their children.

Audience: Child welfare agency personnel; community mental health organizations; psychiatrists; others interested in community child protective services.

Produced by: Affiliated Film Producers.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

READERS' EXCHANGE

HROMADKA: *Important activities*

I was reassured to find in the Chambers-Foster article describing the University of Pittsburgh courses for child-care workers that such preparatory training for child care is possible and workable in the United States; and also to find Mr. Hromadka again stressing the need for such training. "Toward Improved Competence in Child-Care Workers: 1. A Look at What They Do," by Van G. Hromadka; and 2. A Two-Level Training Program," by Guinevere S. Chambers and Genevieve W. Foster, *CHILDREN*, September-October 1966.]

However, while we hope the near future will bring more extensive courses both to prepare workers as well as to give training to those already on the job, we should also recognize what is already being done across the country, here and now. This year the University of North Carolina School of Social Work commemorated the 20th year of summer workshops for child-care workers; St. Louis University had its 10th anniversary of month-long institutes. There are a number of week-long institutes each year at, among other places, Minneapolis, Minn., Syracuse, N.Y., Buffalo, N.Y., Austin, Tex., Louisville, Ky., and at St. Louis, Mo. (Washington University). The University of Washington School of Social Work, Seattle, holds summer classes both for child-care workers and for supervisors. The University of Wisconsin offers four 2-day seminars each year in addition to a sequence of four 17-session courses.

The number of schools of social work offering courses is increasing. These are usually around 15 sessions in length. During the past 2 years, the University of Tennessee School of Social Work has initiated a program of houseparent training with basic courses being offered in four cities. During the 1966-67 academic year, it will offer, in addition, two "advanced" courses and

another basic course in a fifth locality. The Hunter College School of Social Work and the Columbia University School of Social Work have been giving courses for many years.

The University of Wisconsin this year introduced still another type of instruction, a correspondence sequence, with the first course entitled "Institutional Care for Children and Youth."

In the summer of 1965, to test the feasibility of prevocational training, the Houseparent Training Committee of the Welfare Council of Chicago and the Jane Addams School of Social Work conducted a 10-week demonstration project, giving full-time training to 23 students, including fieldwork.

All these activities indicate that there is movement and imagination in the direction of better training for child-care workers. These efforts will be strengthened when institutions themselves take greater responsibility for more consistent inservice training.

Surely all these efforts add up to something important—a gain not only in knowledge and insight on the part of child-care workers but also in a sense of recognition and feeling of identification with child care as a developing profession.

Eva Burmeister
Milwaukee, Wis.

CHILMAN: *Use of statistics*

"Although 'a little knowledge is a dangerous thing', not using that which we have been can be even more dangerous. But the use must be guided by wisdom." These are the closing words of the article by Dr. Catherine S. Chilman. ["Some Differences Between People and Statistics," *CHILDREN*, May-June 1966.] It is unfortunate that the author was apparently more concerned with the dangers of not using what she had than with being guided by wisdom.

On page 102, Dr. Chilman states that "... a measurement of ... vari-

ability [is] commonly called the variance or standard deviation. . . ." I will not dispute this interesting assertion, although persons holding this view might be interested to learn that statisticians commonly call the standard deviation the square root of the variance.

On page 103, the author asserts that "... one point needing emphasis is that the size of a sample is generally not so important as the method of choosing a sample." The knottier problem of "choosing" is immediately solved in the following sentence. "Studies are far more likely to tell something about a group of people in general if investigations are planned in such a way as to provide for a random sample. . . ." This is a gross oversimplification, the extent of which can be gauged easily by reference to any standard text on sampling.

Sample method, sample size, and variance are in fact interdependent. The variance itself may be a very misleading statistic when the population is not normally distributed.

The discussion of statistical and practical significance on page 101 is also misleading. The level at which statistical significance is established is a statistician's tool that can be misused like any other tool requiring skill to operate. In proper hands it can save a tremendous amount of time in the research process. If one found a characteristic under investigation to be three times as prevalent in group A as in group B and that this difference was significant at the level specified, this should, I would think, be suggestive in pursuing further research. Whether most of the group exhibits this characteristic is beside the point.

As a practitioner I am quite aware of potential pitfalls in the use and abuse of statistical analysis. Warnings coupled with substantial abuses of their own hardly help the cause of statistics, research, or, in the final analysis, people.

Marvin M. Engel
Director of Research and Statistics
National Travelers Aid Association
New York

Author's reply

Mr. Engel makes some excellent points in his letter, all of them valid. The points are of particular relevance to persons who are specializing in the field of research and statistics. The

article was addressed to practitioners and represented an attempt to translate a very complex subject into a readily understandable one for nonresearchers whose job it is to use research findings in program development and practice in the health and welfare fields.

In reference to Mr. Engel's discussion of statistical significance, I attempted

to make the point that statistically significant findings have a different set of meanings for researchers than for practitioners. Researchers, very properly, are seeking basic knowledge; practitioners, very properly, are seeking implications from research for action programs. For the practitioner, findings that apply to majorities *do* have prag-

matic meaning, though this is not necessarily an essential for the researcher.

I am grateful to Mr. Engel for raising some important issues for further clarification.

Catherine S. Chilton
Social Science Analyst
Welfare Administration

guides and reports

EDUCATING THE TEENAGER IN HUMAN RELATIONS AND MANAGEMENT OF RESOURCES. American Home Economics Association, 1600 20th Street NW., Washington, D.C., 20009. 1965. 107 pp. \$1.

Eighteen selected papers and discussion summaries from the 1965 annual meeting of the American Home Economics Association.

TULSA CHILD HEALTH STUDY: report of health service. Child Health Study Committee, Tulsa, Okla. Coordinated by the Tulsa Council of Social Agencies in cooperation with the Division of Maternal and Child Health, Oklahoma State Department of Health; and Region VII, Department of Health, Education, and Welfare, Children's Bureau, Dallas, Tex. February 1966. 133 pp. Single copies free upon request (while they last) from the Tulsa Council of Social Agencies, 602 South Cheyenne Street, Tulsa, Okla., 74119.

Includes the reports of nine consultants who participated in a study of the maternity and child health services in Tulsa and their recommendations for improvement.

MENTAL ABILITIES OF CHILDREN FROM DIFFERENT SOCIAL-CLASS AND CULTURAL GROUPS. Gerald S. Lesser, Gordon Fifer, and Donald H. Clark. Monographs of the Society for Research in Child Development, University of Chicago Press, 5750 Ellis Avenue,

Chicago, Ill., 60637. Vol. 30, No. 4, 1965. 115 pp. \$3.

Examines differences in both the level and pattern of scores for four types of mental ability (verbal, reasoning, numerical, and space conceptualization) in first-grade children from four different ethnic backgrounds (Chinese, Jewish, Negro, and Puerto Rican), divided into middle and lower social class groups. The authors report that both social class and ethnicity and their interaction seem to affect intellectual performance, but suggest that more nearly precise testing procedures, free of class or cultural bias, are needed.

EQUALITY THROUGH INTEGRATION: a report on Greenburgh School District No. 8. Naomi and Arnold Bucheimer. Anti-Defamation League of B'nai B'rith, 315 Lexington Avenue, New York, 10016. 1965. 71 pp. \$1.50.

An analysis of the 15 years' experience of complete racial integration in a public school district in Westchester County, N.Y., where specific programs were based on groupings, balanced in both race and ability, and curriculum designed to determine, develop, and challenge each child's ability.

RESEARCH IN SOCIAL FUNCTIONING IN HEALTH AND ILLNESS: An Annotated Bibliography. Lynda L. Holmstrom and William T. Hall. Social Research Program in Heart Disease, Division of Clinical Social Work, Stanford University School of

Medicine, 300 Pasteur Drive, Palo Alto, Calif., 94304. 1965. 16 p. Single copies available free on request from the Director, Social Research Program in Heart Disease.

The 270 books and articles included in this bibliography are listed under six groupings: concepts of health and disease; the patient's reaction to medical procedures and hospitalization; the impact of disease and disability on the patient; the patient's family; society's reaction to illness and disability; and methodology.

INFANT AND PRESCHOOL MENTAL TESTS: review and evaluation. Leland H. Stott and Rachel S. Bal. Monographs of the Society for Research in Child Development, University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill., 60637. Vol. 30 No. 3, 1965. 151 pp. \$3.

Reports on a project to determine and evaluate the types of devices and methods being used to test the mental ability of infants and preschool children.

ADVANCES IN PLANNED PARENTHOOD: proceedings of the annual meeting of the American Association of Planned Parenthood Physicians April 29-30, 1964, Dallas, Tex. Edited by Aquiles J. Sobrero and Saral Lewit. Schenkman Publishing Company, Inc., One Story Street, Cambridge, Mass., 02138. 1965. 151 pp. \$5.95.

The 16 papers included here discuss problems of planned parenthood clinics and research in fertility control, planned parenthood programs in public health and welfare agencies, and research and experience with methods of fertility control.

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

QUEST FOR EQUALITY: the story of how six institutions opened their doors to serve Negro children and their families. Martin Gula. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 441. 1966. 50 pp. 60 cents.

This publication presents principles for racially desegregating an institution previously open only to white children—from the planning stages, through reparation of staff, children, parents, and the neighboring community, to dealing with ensuing difficulties.

The principles are illustrated in case reports on the racial integration of children and staff in six previously segregated institutions written by their administrators—institutions for dependent, neglected, retarded, and disturbed children, and adolescent unwed mothers.

ARE INBORN ERRORS OF METABOLISM IN CHILDREN WITH MENTAL RETARDATION. Donough O'Brien, M.D. Department of Health, Education, and Welfare, Welfare Administration, Children's Bu-

reau. CB Publication No. 429. 1965. 100 pp. 70 cents.

Directed to pediatricians and other professional persons concerned with mental retardation, this publication, divided into two parts, focuses its attention mainly on those rare metabolic disorders in children associated with mental retardation that require laboratory diagnoses because of ill-defined physical signs. Part I presents brief up-to-date clinical and laboratory findings, diagnostic and screening tests, and summaries of available information on the biochemistry, genetics, and treatment of these disorders. Part II presents a detailed description of technical procedures for diagnosing these disorders.

SOME FACTS AND FIGURES ABOUT CHILDREN AND YOUTH.

Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 19 pp. Single copies available from the Bureau without charge.

Through answering 53 questions relating to the health and welfare of children and youth, this pamphlet presents

statistics on child population, families living in poverty, infant and childhood mortality, and juvenile delinquency; information on maternal and child health, crippled children's, and child welfare services, and laws relating to child abuse and phenylketonuria; and the amounts of congressional authorizations and appropriations for Children's Bureau programs.

LEGAL BIBLIOGRAPHY FOR JUVENILE AND FAMILY COURTS. William H. Sheridan and Alice B. Freer. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 46 pp. 35 cents.

Lists 400 selected articles, case decisions, law reviews, reports of conferences and programs, and other references on legal work with juvenile delinquents and with families—court administration and organization, criminal law and procedures, probation services, due process for juveniles, adoption and custody, the law and the indigent, and family courts and family law, among others. A supplement to this listing will be prepared annually.

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